



**HAVERHILL POLICE DEPARTMENT
AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

EMPLOYEE NAME: _____

To be completed by Cook & Company Insurance Services, Inc.	
CLAIM #:	_____
TO:	_____
(health care provider)	DATE: _____

and any other physicians, hospitals, clinic or medical care provider, presently unknown to me, who may have or subsequently acquire information concerning my physical condition related specifically to an incident that occurred on _____ and for which application for IOD had been made.

You are hereby authorized to give to COOK AND COMPANY INSURANCE SERVICES, INC. or any of its representatives, all information, facts and particulars, including reports, records, results from diagnostic tests, x-rays and statements of charges which may be requested regarding my medical condition, diagnosis, treatment rendered, prognosis, estimates of disability, or recommendations for further treatment and to furnish them copies of such reports. You are further authorized to allow any physician appointed by them to review all such reports, records and x-rays in your possession.

I authorize a facsimile or photocopy of this document can be accepted with the same authority as the original.

This information is to be used for purposes of evaluating and handling my work place injury, and for no other purpose, now or in the future.

THIS AUTHORIZATION EXPIRES ON CONCLUSION OF CLAIM.

EMPLOYEE SIGNATURE: _____

**Cook & Company Insurance Services, Inc.
Injured-on-Duty Division
1025 Plain Street, P.O. Box 1068
Marshfield, MA 02050
(781) 837-7300
Fax: (781) 834-7245**