



ALABAMA ORTHOPAEDIC CLINIC, P.C.

AUTHORIZATION FOR TREATMENT FOR WORK-RELATED INJURIES

The undersigned does hereby authorize and consent to the professional services rendered by Alabama Orthopaedic Clinic, P.C. for a work related injury occurring on _____ while employed by _____. Any treatment or charges incurred to that which is not related to the work injury referenced above is the sole responsibility of the patient.

The undersigned does hereby authorize the release of such information that may be necessary for the completion of medical insurance claims and insurance payments of medical benefits to Alabama Orthopaedic Clinic, P.C.

Patient Signature

Print Name

Witness

Date