Injured worker SIGNS, returns to employer's office
Employer returns to S & C CLAIMS SERVICES, INC.

B

REQUEST FOR ADDITIONAL MEDICAL INFORMATION AND RELEASE FORM
PETICION PARA INFORMACION MEDICA Y FORMA DE DESCARGO

Injured Worker's Name: _____
Nombre del Trabajador Lesionado:

Claim Number: _____
Numero de Reclam

Social Security #: _____
Numero de Seguro Social:

Injury Date: _____
Fecha de Accidente:

Employer: _____
Nombre de la Compania/Empresa:

Employer's Address: _____
Direccion de la Compania/Empresa:

I, the undersigned injured worker, or legal representative of the injured worker named above, do hereby certify that the information provided below is complete, true and correct to the best of my knowledge and that I have provided that information in order to obtain the benefits provided for by all applicable codes and rules as adopted by the Utah Labor Commission. I hereby authorize any physician, chiropractor, practitioner, or other person, any hospital, including Veteran's Administration or other governmental hospital, any medical service organization, any insurance company, or other entity or organization, governmental or private, to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or any other disabilities or injuries. A photocopy of this authorization shall be as valid as the original.

Signature
Firma

Date
Fecha

Please provide the information requested below, sign and date the form, and return it to your insurer. Your signature on this form also acts as a release to acquire information affecting your claim from other entities. *Failure to complete and return this form to your claims administrator in a timely manner could affect your benefits or delay the resolution of your claim.*

PLEASE CHECK THE APPROPRIATE BOX BELOW AND PROVIDE THE INFORMATION REQUESTED

PRIOR HISTORY INFORMATION

☐ I have no prior conditions, injuries, or disabilities, of which I am aware, that might affect the disposition of the claim referenced above. If you checked this box, no further information is needed at this point. *Yo no tengo ningunas condiciones, lesiones, o desabilidades anteriores, de cual yo tenga conocimiento, que puedan affectar la disposicion de el reclamo mencionado arriba. Si usted marca esta caja, ninguna informacion adicional es necesaria en este momento.*

☐ I have a prior condition, injury, or disability that could affect the disposition of the claim referenced above (this can include birth defects, prior surgeries, injuries, etc., whether work related or not). If you checked this box, indicating a pre-existing condition, please explain in detail in the space below. You are encouraged to attach additional sheets of paper to this form if necessary to fully explain the condition. Yo tengo una condicion,lesion, o disabilidad anterior la cual pueda affectar mi reclamo mencionado arriba (esto puede incluir defectos de nacimiento, cirugias/operaciones anteriores, lesiones, etc., aunque sea o no relacionado al trabajo). Si usted marca

_____

_____

S & C CLAIMS SERVICES, INC.
P.O. Box 12564
Salem, OR 97309
Toll Free (800) 362-5198
Fax (503) 485-2299

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