

**WORKERS' COMPENSATION
LETTER OF AUTHORIZATION TO EMPLOYER**

DATE: _____

EMPLOYER: _____

EMPLOYEE: _____

DATE OF ACCIDENT: _____

INSURANCE CARRIER: _____

By Telephone _____ Date _____ Talked With _____

The above patient has reported to our office for examination and treatment due to injuries received while on the job, and states you are his/her employer. Please sign and return this written authorization for treatment to our office.

Signature

Title

****NOTE**** If this acknowledgement is not signed and returned to this office, or if we do not hear from you within seven (7) days, and if the above patient continues to receive treatment after seven (7) days, it will be assumed and relied upon that the insurance company listed above has agreed to and acknowledges medical coverage and authorization for treatment.