DR. GARY BIRDSALL
MEDICAL CLINIC, LLC

WORKMAN COMPENSATION
VERIFICATION / CONSENT / AND RELEASE OF INFORMATION FORM

Date: _____ Time: _____

Patient's Name: _____ DOB: _____

Address: _____ Phone #: _____

Male / Female Marital Status: M S D W

Date of accident / injury: _____

Brief description of accident / injury: _____

_____

_____

Employer Name: _____

Employer Address: _____ Phone #: _____

Verified by: _____ Position: _____

CARRIER Name: _____

Carrier Address: _____ Phone #: _____

Contact person: _____

Verified by: _____ AUTH / CLAIM #: _____

I hereby give permission to be treated at Dr. Gary Birdsall Medical Clinic, LLC, for:

_____

Signature: _____ Date: _____

I hereby give permission for Dr. Gary Birdsall Medical Clinic, LLC, to release information to: _____

_____ in reference to my accident / injury.

Signature: _____ Date: _____