

MARK D. EPSTEIN, M.D., F.A.C.S.

Worker's Compensation

Were you injured on the job? _____ Date of injury: _____

Are you still working? _____ If no, last date worked: _____

Worker's Compensation carrier: _____

Address: _____

City: _____ State: _____ Zip: _____

Claim #: _____

Policy #: _____

WCB #: _____

Employer at the time of injury: _____

Address: _____

City: _____ State: _____ Zip: _____

I, _____ hereby authorize payment of Worker' compensation benefits directly to Mark D. Epstein, M.D. In the event that I fail to file a claim for Worker' compensation benefits for this illness or condition, or it is determined by the Worker' compensation carrier that the illness or condition is not a result of a compensable Worker' compensation case, I hereby agree to pay Mark D. Epstein, M.D. his usual and customary fees for all services rendered.

I HEREBY AUTHORIZE MARK D. EPSTEIN, M.D. TO RELEASE INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO BE RELEASED TO MY WORKER' COMPENSATION CARRIER AND/OR MY ATTORNEY.

Signature: _____

Date: _____