Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
800-332-2667

FORM C-31

MEDICAL WAIVER AND CONSENT

This form is not required for injuries occurring on or after July 1, 2014

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE BUREAU OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. § 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I,_____, having filed a claim for workers' compensation benefits, do hereby authorize
(Printed Patient Name)

_____ to furnish to my employer or my employer's
(Name of Medical Provider)

representative, and/or the Bureau of Workers' Compensation any information or written material reasonably related to my

work-related injury of _____for which I am claiming compensation. I further authorize the release of
(Date of Injury)

the same information to me or my attorney. The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

A photocopy of the authorization may be accepted in lieu of the original.

_____

Patient Signature Date Date of Birth

Oficina de Compensación a Trabajadores de Tennessee
Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
800-332-2667

FORMULARIO C-31
FORM C-31

CONSENTIMIENTO Y EXENCIÓN MÉDICA
MEDICAL WAIVER AND CONSENT

Este formulario no es requerido para lesiones que ocurrió el 1 de julio de 2014 o antes
This form is not required for injuries occurring on or after July 1, 2014

ESTE FORMULARIO DE AUTORIZACIÓN MÉDICA SOLAMENTE PERMITE QUE EL EMPLEADOR O LA OFICINA DE COMPENSACIÓN A TRABAJADORES OBTENGA INFORMACIÓN MÉDICA MEDIANTE COMUNICACIÓN ORAL O POR ESCRITO, INCLUYENDO PERO NO SE LÍMITA A GRÁFICOS, ARCHIVOS, REGISTROS, E INFORMES EN LA POSESIÓN DE UN PROVEEDOR MÉDICO AUTORIZADO POR EL EMPLEADOR SEGÚN T.C.A. § 50-6-204 Y UN PROVEEDOR MÉDICO QUE ES REEMBOLSADO POR EL EMPLEADOR PARA EL TRATAMIENTO DEL EMPLEADO.

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE BUREAU OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. § 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

Yo, _____ habiendo presentado una reclamación para beneficios de compensación a trabajadores, por el
(Nombre del Paciente en letra de molde)
presente autorizo a_____ a que proporcione a mi empleador o al representante de mi empleador y/o a la
(Nombre de Proveedor Médico)
Oficina de Compensación a Trabajadores cualquier información o material escrita ascociada razonablemente a mi lesión con relación al trabajo de _____ para la cual estoy reclamando compensación.
(Fecha de Lesión)
Adicionalmente, autorizo la divulgación de la misma información para mí o para mi abogado.

I, _____, having filed a claim for workers' compensation benefits, do hereby authorize
(Printed Patient Name)
_____ to furnish to my employer to furnish to my employer or my employer's
(Name of Medical Provider)
representative, and/or the Bureau of Workers' Compensation any information or written material reasonably related to my work-related injury of _____for which I am claiming compensation.
(Date of Injury)
I further authorize the release of the same information to me or my attorney.

La autorización incluye, pero no se restringe al derecho de revisar y obtener copias de todos los registros, radiografías, informes de radiografías, gráficos médicos, recetas, diagnósticos, opiniones y cursos de tratamiento.
Una fotocopia de la autorización puede ser acceptada en lugar del original.

The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.
A photocopy of the authorization may be accepted in lieu of the original.

Firma del Pacient Patient Signature	Fecha Date	Fecha de Nacimiento Date of Birth