# Authorization to Release Medical Records

**Injured Worker’s Name:**

**Claim Number:**

I authorize any professional to furnish any of my records or reports to Peak Performance of Cambridge, Ltd. or their representatives. I authorize you to permit Peak Performance of Cambridge, Ltd. or their representatives to inspect and make copies of any and/or all records or reports. This authorization will be in effect for as long as I am a candidate for or a participant in rehabilitation programming. I waive and release any professional from any legal restrictions in furnishing any records, reports or communication to Peak Performance of Cambridge, Ltd. or any of their representatives.

I also authorize Peak Performance of Cambridge, Ltd. or any of their representatives to furnish information to any service provider or to any state or federal agency which may be considering providing me with services or benefits.



\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Injured Worker’s Signature Date