

SAGINAW CHIPPEWA INDIAN TRIBE  
SOARING EAGLE CASINO & RESORT  
COMP ONE ADMINISTRATORS, INC.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS & REPORT

The undersigned person hereby consents to, and by this authorization, or any photocopy thereof, authorizes the release to Saginaw Chippewa Indian Tribe/Comp One Administrators or any of requested regarding my physical condition and treatment rendered by you thereof, and if necessary, to allow them or any physician appointed by them, to examine any and all medical reports, histories, findings, prognosis, bill information, and other documents related to any medical treatment, hospitalization, prescription drugs, or other medical services or supplies, which you may have regarding my condition or treatment.

The undersigned person understands and hereby acknowledges that the information above, or certain portions thereof, may be protected from disclosure without this signed authorization by federal and state privacy and confidentiality laws.

Patient Name:(printed)\_\_\_\_\_

Signature:\_\_\_\_\_Date:\_\_\_\_\_

Date Of Injury:\_\_\_\_\_