

**HOSPITAL) PERMISSION SLIP
DOCTOR)**

To:

Claimant :
Insured :
Date of Acc. :
Claim No. :

Permission is granted to furnish A.I.M. Mutual Insurance Cos. and their authorized agents or representatives, as well as the above named insured/employer, with a copy of my record of treatment for the above date of accident.

Lab Rule 503.01(b): This request is strictly limited to medical information relevant to the occupational injury or illness that underlies the patient's workers compensation claim, including any past history of complaints of, or treatment of, a condition similar to that claim.

A.I.M. Mutual Insurance Cos. will be responsible for payment of your usual charge for such a copy.

You are authorized to permit the examining physician for A.I.M. Mutual Insurance Cos. to examine any x-ray or films you may have concerning my condition.

My permission is also given for you to accept a photocopy of this authorization.

(Signature)

(Date of Birth)

(Date)

Send Record to:

**A.I.M. Mutual Insurance Cos.
P.O. Box 4070
Burlington, MA 01803-0970**

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