CROSS COUNTRY
INFRASTRUCTURE SERVICES INC.

Authorization for Release of Medical Information

Patient: ____

To Whom It May Concern:

You are hereby expressly authorized to release and furnish to Cross Country Infrastructure Services and/or any associate, assistant representative, agent, or employee thereof, any and all desired information (including, but not limited to, office records, medical reports, memos, hospital records, laboratory reports, including results of any and all tests including alcohol and/or drug tests, X-rays, X-ray reports, including copies thereof) pertaining to the physical and/or mental condition which is the basis of my worker's compensation claim. This includes not only current and/or future information, but also all past medical information.

PRINT/ FIRST NAME: ___________________ LAST NAME: ______________________

Photo static copies of this signed authorization will be considered as valid as the original.

This is not a release of claims for damages.

DATED: _________________________________ SIGNED: ____________________________

PLEASE SIGN THE ABOVE MEDICAL AUTHORIZATION AND RETURN IT SO THAT WE MAY SECURE RELEASE OF YOUR MEDICAL RECORDS.

Thank you,

Cross Country Infrastructure Services, Inc.