Claim No.:

NOTICE OF MY PHYSICIAN CHOICE

Employee's Name _____

Employee's Social Security Number _____

Employer's Name _____

Injury Date _____ **Part of Body Injured** _____

MWCC No. _____ **Insurance Carrier or TPA No.** _____

I am claiming to have sustained a work related injury or illness. **I understand that my signature on this form has legal consequences and is binding on me.**

I understand that under the Mississippi Workers' Compensation Law I have the right to choose one physician to render treatment to me. I also understand that any referral to any other doctor must be made by my one chosen physician.
My employer may tender treatment to me by a physician of its choosing, and I understand that I can either accept the physician to whom I am sent by my employer or I can choose a different physician.
I also understand that after I make my choice, my employer or it workers' compensation insurance carrier must approve any physician change. *If, therefore, I change doctors without their permission I may be responsible for all expenses related to the unauthorized treatment.*

With that understanding, I make my choice as follows:

☐ I accept as my choice of physician my employer's tender of treatment by Dr. _____

☐ I elect to choose my own physician to render treatment, and that choice is Dr. _____

I understand that medical information under the Mississippi Workers' Compensation Law is not privileged and that my employer and its workers' insurance carrier are entitled to all medical information such as is necessary to carry out the workers' compensation law. This "choice of physician" form shall therefore also confirm that I authorize any doctor, physician, psychologist, hospital or other provider of medical and related care to release unto and/or discuss with my employer, their agents, employees, workers' compensation insurance carrier, third party administrator, or attorneys, all medical information including reports, psychological tests results, opinions, records, x-rays, x-ray reports, laboratory reports, nurses' notes, physicians' orders , and any and all other documents relating to any examination or treatment of myself.

I hereby agree that a copy of this authorization form shall have the same force and effect as the original and I further agree that this authorization shall remain valid so long as my claim against my employer remains open.

_____
Employee

_____
Date

Witnessed by:

_____

_____

Original – Employer's File
Copy – Employee
Copy – Carrier/Third Party Administrator
Copy - MWCC