



GowrieGroup

ALWAYS ON WATCH.
Insurance • Benefits • Finance

**TOWN OF ROCKLAND
MEDICAL RELEASE AUTHORIZATION**

Today's date: _____

Employee: _____

Employer: ROCKLAND [☐] Police [☐] Fire

GCS claim #: _____

Date of Injury: _____

To: _____

This also applies to any other physicians, hospitals, clinics, or other medical providers, presently unknown to me, who may have or subsequently acquire information concerning my medical condition due to this injury.

You are hereby authorized to provide to Gowrie Group, Gowrie Claims Services, Glatfelter Claims Management, or any of its representatives, all information, facts, particulars, including reports, records, results from diagnostic tests, x-rays or other images, and statements of charges which may be requested regarding my medical condition, diagnosis, treatment rendered, prognosis, estimates of disability, or recommendations for further treatment and the furnish them copies of such information. You are further authorized to allow any physician appointed by them to review all such reports, records, x-rays or other images in your possession.

I agree that a photostatic or electronic copy of this authorization be accepted with the same authority as the original.

***This medical release authorization is for medical information related to this injury only.
This authorization expires at the conclusion of this claim.***

Employee signature: _____

Gowrie Claims Services
P.O Box 578
Brant Rock, MA 02020
Fax: 1-781-536-6930