Mass General Brigham

133 Littleton Road, Suite 202 Westford, MA 01886
Phone: 978-577-1946   Fax: 978-692-4716

Patient Name:	**Date of Birth:**

Address: ____

City: ______________________ State: __________ Zip: _________________________

Phone: ______________

Date of Injury:	**Injured body part(s):**

Employer: ____

Worker's Comp Insurance Carrier:

Address: ____

City: ______________________ State: __________ Zip: _________________________

Case # ____________________Phone: ______________ Fax Number: ______________

Attorney Name:

Address: ____

City: ______________________ State: __________ Zip: _________________________

Case # ____________________Phone: ______________ Fax Number: ______________

Assignment release: I hereby authorize my insurance benefits to be paid directly to Mass General Brigham Community Physicians. I authorize Mass General Brigham Community Physicians to release the information requested on the forms submitted on my behalf.

Signature: __________________________ Date: _________________________________