

MEDICAL AUTHORIZATION

TO WHOM IT MAY CONCERN:

I, _____
Hereby authorize the release of all medical documentation and other information which may be in the possession of any insurer, physician, surgeon, doctor, hospital, ambulance service or nurse, to any representative of

(Hereinafter called "The Company") regarding my injuries, medical history, physical and mental condition prior to and subsequent to the date of this authorization.

Upon presentation of this authorization (or a photocopy), you are authorized to release a copy of these records to any representative of The Company. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient pursuant to applicable law.

The purpose of the disclosure is at my request and this Medical Authorization shall be deemed to comply with the requirements of the Health Insurance Portability and Accountability Act.

This Medical Authorization shall expire upon final resolution of my claim with The Company. I understand that I may revoke this Medical Authorization at any time by sending written notice to The Company and medical providers.

WITNESSES:

PRINT NAME SIGNATURE

PRINT NAME SIGNATURE

SIGNATURE OF CLAIMANT:

PRINT NAME SIGNATURE

SOCIAL SECURITY NUMBER DATE

CLAIM NUMBER