

INSURANCE AUTHORIZATION

TO:

Re:

Social Security No.:

Date of Birth:

The undersigned hereby authorizes you to forward to the law firm of _____

all facts and information pertaining to my insurance coverage, including all records concerning history, medical treatment, any insurance communications, insurance claim forms, records of payment, and any other records in your file pertaining to my insurance coverage. These attorneys are to have full and complete access to any and all of these records and also any further information gained through a business relationship while I was covered by your insurance policy.

I understand that my medical records (including STD, HIV, chemical dependency, psychiatric and/or pharmaceutical records) may be protected by federal and/or state regulations. I hereby authorize said attorneys to redisclose copies of said records and/or information contained therein to other persons, firms and corporations for purposes connected with a pending lawsuit in which I and said attorneys are involved.

The undersigned further states that photostatic copies of this authorization shall have the full force and effect of the original. This authorization shall remain effective for a period of one year from the date on which it has been executed unless you receive notification from the undersigned to the contrary.

Executed this _____ day of _____, 20____.

Signature

Street Address

City, State, Zip

STATE OF _____)
) ss:
COUNTY OF _____)

On this _____ day of _____, 20_____, before me, a Notary Public in and for the county and state aforesaid, appeared _____, personally known to me to be the same person who executed the above instrument and duly acknowledged the execution of the same.

IN WITNESS WHEREOF, I have hereunto set my hand and seal on the date last above written.

Notary Public

My Appointment Expires: