

Claim Number: _____

Authorization For Medical And Hospital Records And Reports

To Whom It May Concern:

This will authorize you to give the bearer of this document all information you may have, without limitation, regarding my medical condition as revealed by your observation, evaluation or treatment and/or any records or other data that you may have access to regarding my condition whether it be past, present and/or future. This access to information is inclusive of, but not limited to, history, findings, diagnostic test results, diagnosis and prognosis.

This authorization to release records extends to any healthcare provider, present and prior employers and any insurance carrier.

I agree that a photocopy of this authorization may be used as the original.

Print Name

Sign Name

Date
