Unit #_____ **American Dream Restaurants LLC**

AUTHORIZATION TO OBTAIN INFORMATION

I authorize any licensed physician, medical practitioner, nurse, pharmacist, hospital, clinic, other medical or medically-related facility, insurance or reinsurance company, consumer reporting agency, employer or former employer that has any information as to the diagnosis, treatment or prognosis of any physical or mental condition of me, and any information regarding my occupation and salary, to give any and all such information to GC Pizza Hut, its employees and reinsurers to which I am submitting a claim.

This request is strictly limited to medical information relevant to the occupational injury or illness that underlies the patient's workers' compensation claim, including any past history of complaints of, or treatment of, a condition similar to that presented in the claim.

I understand that the information obtained by way of this authorization will be used by the Company to determine eligibility for insurance benefits.

I know that I may request a copy of this authorization.

I agree that a photographic copy of this authorization shall be as valid as the original.

I agree that this authorization shall be valid until specifically revoked by me in writing, except revocation will not apply to information already used or disclosed in response to this authorization.

Date:_____/____/_____ Signed: _____
Signature of Claimant or Authorized Representative

Print Claimant Name_____

Social Security #_____

Notice to Health Care Provider: American Dream Restaurants LLC has a Workers' Comp Limited Duty Program to help injured employees get back to work. We will work to provide limited duty assignments, set within the restrictions placed upon an injured employee by a Health Care Provider, until the employee is able to resume his/her regular job functions.

American Dream Restaurants LLC
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