MEDICAL RECORDS RELEASE FORM

To Provider of Services:

_____

I hereby authorize you to release to any attorney, physician, or insurance company involved in my case, any medical or other records or information necessary to process my claim. These records are to be utilized for the ultimate recovery of benefits in my case for the injury/ illness sustained on: _____/_____/_____.

Signature of Patient:_____ Date:_____

ASSIGNMENT OF BENEFITS

To Insurance Company: _____

Provider of Services: _____

I hereby request that you pay directly to this above -mentioned provider of services, any moneys that are due and owing on my case, for services rendered by them to me. This assignment can by submitted by fax or copies and shall be as valid as if it were the original. This assignment may in the future, be revoked by my attorney.

Signature of patient: _____ Date: _____/_____/_____.

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