

CONSENT FOR OBTAINING MEDICAL INFORMATION (Please Read Carefully)

FILE NUMBER: _____

INSURED/CLIENT: _____

DATE OF ACCIDENT: _____

PATIENT'S NAME: _____

AGE: _____

PATIENT'S ADDRESS: _____

NAME(S) AND/OR CLASSES OF MEDICAL PROVIDER(S) AUTHORIZED TO RELEASE MEDICAL INFORMATION:

TYPE OF INFORMATION OR SPECIFIC MEDICAL RECORDS AND DATE(S) OF TREATMENT TO BE RELEASED:

RESTRICTIONS:

PURPOSE – This authorization or copy thereof will allow the person(s) listed above to furnish The Premier Insurance Company of Massachusetts and its legal representatives specific medical information for treatment and diagnosis related to injuries, sickness or disease sustained by the patient and arising out of or related to this accident or medical condition.

- This information will be used only to establish the merit of claims for benefits or damages presented to us.
- This information will not be released to other persons without your permission, except to protect you, ourselves or in compliance with any applicable law, governmental regulation or court order.
- For your protection, the information is not directly available to you. With your consent, it may be provided to your physician or legal representative.
- This authorization can be revoked at any time. It is not valid for more than one year.

I HAVE READ THE ABOVE AND UNDERSTAND THE PURPOSE AND USE OF THIS MEDICAL AUTHORIZATION.

SIGNATURE OF PATIENT (or person authorized to sign on patient's behalf):

DATE: _____