MEDICAL AUTHORIZATION RELEASE FORM

RE: Name:
SSN:
DOB:

TO: _____

I, _____, hereby authorize _____

_____, who treated me for the time period from _____ through present, to release any and all records in your custody, including office records, medical reports, charts, x-rays, and bills concerning my physical or mental condition to Gary William Cunha.

The purpose for this release of information is to assist me and my attorney in anticipated or pending litigation.

A copy of this authorization has the same force and effect as an original. This authority will remain in effect for a period of Two Years from the date hereon or until I revoke same in writing.

I understand that I have the right to revoke this authorization, except to the extent that _____ has taken action in reliance thereon, by providing you with a written request to revoke this authorization.

I understand that information that is disclosed or used under this authorization may be disclosed by Gary William Cunha and no longer protected by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Section 164.508(c).

Signed on _____, 2007.

_____

Print: