# Personal Injury Claimant Authorization to Release Medical Records

I hereby authorize any hospital, clinic, medical provider, physician, doctor, nurse, therapist, insurance company, or any other entity or person that has provided me medical care or received information regarding my medical condition to release copies of all medical records, reports, charts, bills, notes, and any other information pertaining to my health, treatment, diagnosis, and prognosis.

This authorization is for the purpose of evaluating and processing my personal injury claim, including but not limited to insurance and legal proceedings.

Claimant Full Name:

Date of Birth:

Address:

Phone Number:

Claim/File Number (if applicable):

☐ I understand I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance upon it.

☐ This authorization expires one year from the date signed below, unless revoked earlier in writing.

☐ A photostatic or electronic copy of this authorization shall be as valid as the original.

Signature:

_____

Date:

_____

If signed by legal representative:

Relationship to Claimant: