Third-Party Information Release Authorization

For Personal Injury Claims

I hereby authorize the release of any and all information related to my personal injury claim as specified below.

Full Name of Claimant

Date of Birth

Claim/File Number (if applicable)

Address

Phone Number

Information to be Released

- Medical Records (including diagnosis, treatment, and prognosis)
- Billing and Payment Information
- Employment and Income Information
- Insurance Documentation
- Other relevant information pertaining to the injury claim

Recipient(s) of Information

Name(s) of Authorized Third Party/Organization

Relationship to Claimant

Purpose of Disclosure

Authorization and Consent

I understand that this authorization is voluntary and I may revoke it at any time by providing written notice. I understand that the information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization expires: (Enter date or event).

A copy or facsimile of this authorization shall be considered as valid as the original.

Signature of Claimant _____ Date _____

If signed by representative, indicate authority (e.g., guardian, attorney):

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