LOCAL FORM 1.

TO ____________________________________
[Individual Provider Name Must Be Inserted]

RE:

PATIENT NAME: ________________________________

D.O.B.: ________________________________

S.S.N.: ________________________________

DATES OF
TREATMENT: ________________TO ____________
[Releasor to Designate Relevant Time Period]

AUTHORIZATION TO RELEASE MEDICAL RECORDS

THIS DOCUMENT DOES NOT AUTHORIZE THE RELEASE OF ANY RECORDS CONCERNING OR RELATED TO ANY ALCOHOL, DRUG, HIV OR PSYCHIATRIC CARE, TESTING OR TREATMENT

You are hereby authorized and requested to furnish the following to the law firm of ____ [Individually Authorized Law Firm Must be Specified]. This authority to Release includes, but is not limited to: medical reports, clinical notes, nurse's notes, history of injury, subjective and objective complaints, x-rays, x-ray reports or interpretations, other diagnostic tests (including a copy of the report), diagnosis and prognosis; if applicable, emergency room records or logs, history and physical examination report, laboratory reports, tissue committee reports, reports of operation, operation logs, progress notes, doctors' orders, nurse's notes, physical therapy records, admission and discharge summaries, and all out-patient records; hospital bills, bills for the services you have rendered, bills for medication; and any

other documents, records, or information in your possession relative to my past, present or future physical condition.

I hereby expressly waive any laws, regulations and rules of ethics which might prevent any hospital, doctor or other person, who has treated or examined me in a professional capacity, or otherwise, from releasing my records subject to this Release.

I hereby authorize you or any member or employee of your office or association, who has examined or treated me, as well as any hospital in which I have been a patient, to produce and release to the person presenting this form complete and legible copies of any and all information concerning my physical condition, care and treatment. This form is valid for one year from the date of execution.

THIS IS NOT AN AUTHORIZATION FOR THE ABOVE-MENTIONED ATTORNEY OR LAW FIRM TO OBTAIN OR REQUEST STATEMENTS, OPINIONS, INTERVIEWS OR REPORTS WITH ANY OF MY MEDICAL PROVIDERS.

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[Signed by Party]

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[Date]