

## **MEDICAL AUTHORIZATION**

This form, signed by: \_\_\_\_\_ ,  
(Patient Name - Please Print)

on behalf of: \_\_\_\_\_ ,

will authorize: \_\_\_\_\_  
(Name of Physician(s))

to release all medical information and records pertaining to injuries sustained as a result of:

\_\_\_\_\_ on or about \_\_\_\_\_

to ***Townsend & Leedham Adjusters Ltd.*** for the purpose of determining the appropriate information of an injury accident claim for insurance.

This authorization includes:

- All medical history and physical condition prior to and subsequent to the event in question, regardless of elapsed time.
- Copies of all diagnostic and other "third party" reports.
- Copies of all information provided to any Accident Benefits Insurer or any other Insurer providing disability and/or medical expense coverage.

### **THIS IS NOT A RELEASE OF CLAIM FOR DAMAGES**

I understand why I have been asked to disclose my individually identifying information, and am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure. I understand that I may revoke this consent at any time.

Date of consent: \_\_\_\_\_ End date of consent (if any)\*: \_\_\_\_\_

\* Consent is no longer valid after this date.

Signature : \_\_\_\_\_

Witness : \_\_\_\_\_ Witness Signature : \_\_\_\_\_  
(Please Print)