REQUEST FOR MEDICAL INFORMATION

DATE: _____POLICY NUMBER: _____

INSURED'S NAME: _____

AUTHORIZATION

I hereby authorize _____ to:
(Insurance Company Name)

_____ Provide the reasons for the rated policy

_____ Release medical information to me

_____ Release lab results to me

_____ Release medical information and lab results to the designated medical professional below

Name and address of person to whom medical information should be sent:

_____

_____

_____

This authorization will expire six months after receipt by CPS Insurance Services.

DATE: _____SIGNATURE: _____