

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 Trust Financial Services.

DATE: _____ SIGNATURE: _____