AUTHORIZATION TO RELEASE CLAIM HISTORY AND COVERAGE VERIFICATION

Please complete in full.

Authorized Company/Organization Name: ______________________________

Authorized Representative: _________________________

By signing this form I authorize the release of my coverage and claim history to the organization indicated above. This authorization is valid for 6 months after the signature date.

Printed Name of Provider:__________________________________

____ _________________________

Signature of Provider (NO STAMPED SIGNATURES ACCEPTED) Signature Date