MEDICAL AUTHORIZATION /RELEASE OF INFORMATION

Name: _____

Claim Number: _____

I authorize any physician, surgeon, dentist, hospital, rehabilitation/convalescent/custodial facility, ambulance owner, nurse or insurance company to furnish any representative of *NurseValue, Inc.* all records in their possession regarding ***(enter date of injury)*** injuries, medical history, and physical condition both before and after of the above date, regardless of the time of occurrence. This information will be used for the purpose of verifying, evaluating, negotiating and other pertinent legal uses, with respect to the patient's claim.

THIS AUTHORIZATION SHALL REMAIN VALID UNLESS REVOKED IN WRITING WITH NOTICE TO *NurseValue, Inc.* EFFECTIVE FOR ONE YEAR FROM THE DATE SIGNED OR FROM THE DATE THE CLAIM HAS BEEN LEGALLY CONCLUDED, WHICHEVER OCCURS FIRST.

Upon presentation of this authorization, or a photocopy of it, you are directed to permit the personal review or photocopying of the information by any representative of *NurseValue, Inc.*

I, as the patient or authorized representative, understand that a copy of this authorization will be furnished upon request.

THIS IS NOT A RELEASE OF CLAIM FOR DAMAGES

_____
SIGNATURE

_____
DATE SIGNED

_____
SOCIAL SECURITY NUMBER

☐ A copy has been received by the patient or authorized representative

_____
PATIENT OR AUTHORIZED REPRESENTATIVE

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