

AUTHORIZATION TO FURNISH MEDICAL INFORMATION

PATIENT:		
CLAIM:		
TO WHOM IT M	1AY CONCERN:	
Mutual Insurand past and presen	ce Company and t	hereof, which is unlimited as to time, will authorize you to release to The Beacon cheir appointed representatives all information you may have regarding my condition or observation or treatment, including but not limited to: history obtained, x-ray and prognosis.
	Print Name:	(As it appears on your Social Security card)
	SIGNATURE:	(As it appears on your social security card)
	State Relationsh	nip if not Patient:
	Patient's Date o	f Birth:
	Patient's Social	Security #:
	DATE:	