MEDICAL RELEASE FORM

PROVIDER: _____

ADDRESS: _____

_____

I authorize the disclosure of all protected medical information to Morgan-White Administrators International, Inc. or any other member, associate or designee of the firm. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information including but not limited to the following: all medical records, hospital records: including inpatient, outpatient and emergency room treatment, all clinical charts, reports, office and doctor's handwritten notes, correspondence, medical bills, records received from other physicians, lab reports, x-rays, and anesthesia records. All costs incurred in connection with this medical authorization shall be paid by Morgan-White Administrators International, Inc.

I understand that I may revoke this authorization at any time by sending a letter to Morgan-White Administrators International, Inc. The revocation is effective upon receipt but will have no impact on uses or disclosures made while that authorization was valid.

Any facsimile, copy of photocopy of the authorization shall authorize you to release the records herein. This authorization expires two years from the date below.

INSURED'S NAME: _____

INSURED'S SIGNATURE: _____

DATE: _____