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Disclosure Authorization

Claimant's Name:

NOTE: This form is to be completed by the claimant or their authorized representative. It authorizes the release of information to the appropriate parties for the purpose of resolving the claim. The information released may include, but is not limited to, medical records, test results, and other relevant information. This authorization is valid for the duration of the claim and may be renewed as needed.

AUTHORIZATION

I, the undersigned, do hereby authorize the release of information to the appropriate parties for the purpose of resolving the claim. This authorization is valid for the duration of the claim and may be renewed as needed.

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IMPORTANT CLAIM NOTICE

Colorado Residents:

District of Columbia Residents:

Florida Residents:

Kentucky Residents:

Maryland Residents:

Minnesota Residents:

Pennsylvania