PATIENT

INFORMATION RELEASE/AUTHORIZATION FORM

- I, ("Client"), authorize Medical Recovery Services, Inc. to negotiate settlements of the attached invoices with health care provider(s), subject to my right to revoke such authorization at any time prior to my written approval of a settlement.

- I have authorized the disclosure of my individually identifiable health care information to Medical Recovery Services, Inc.

- I understand that Medical Recovery Services, Inc. makes no claims as to the competency and/or qualifications of the provider(s).

- By signing below, I agree to hold harmless Medical Recovery Services, Inc. from any and all liability with respect to services provided by health care provider(s).

Client Signature: _____

Printed Name: _____

Patient Date of Birth: _____

Social Security Number: _____

Date: ___ ____/_20____