

MEDICAL AUTHORIZATION AND ASSIGNMENT

I, \_\_\_\_\_, HEREBY AUTHORIZE  
\_\_\_\_\_ (Name of doctor, hospital,  
medical facility, clinic, etc.) To furnish or release to \_\_\_\_\_  
\_\_\_\_\_, Attorney at Law, any and all requested  
medical information, case history, or files transferred from  
other doctors, hospitals, medical facility, or clinic, of  
whatsoever nature. By signing this authorization I also hereby  
cancel any prior authorizations.

I HEREBY AUTHORIZE \_\_\_\_\_ (attorney) to pay any  
outstanding medical bills directly from the proceeds of any  
recovery which I may receive.

DATED this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_.

\_\_\_\_\_  
Client Signature