

**Authorization for Use and/or Disclosure
of Protected Health Information**

I, _____, consent to and authorize

to release to any and all attorneys employed by the law firm of Brown, Brown & Brown,
P.L.L.C., PO Box 400, Albemarle, North Carolina 28002 (fax 704-982-0902)

the following information:

Any and all medical information they may request concerning the nature and extent of my injuries and treatment administered regarding the accident I was involved in on _____ . Please release all the medical information to them including, but not limited to, clinical notes, admittance and discharge summaries, any medical histories, radiology reports, lab reports, final reports, physicians' and nurses' notes/summaries, diagnostic results physical therapy and occupational therapy notes, and medical bills for the period from _____ through _____. Your full cooperation with my attorneys is respectfully requested. The information will be used/disclosed for legal purposes.

I understand that the information may include information related to sexually transmitted disease, behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

I understand that this authorization is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed by law. I understand that any photocopy of this document will be considered as valid as an original.

I understand I may revoke this authorization at any time by sending a notice of revocation in writing to you. I further understand that I may not revoke this authorization to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization expires on the following date or event: _____.

This the _____ day of _____, _____.

Signature of Patient or Legal Representative

Patient's Date of Birth

Relationship to Patient/Authority to Act

Patient's Social Security Number

Signature of Witness