AUTHORIZATION TO FURNISH MEDICAL INFORMATION

PATIENT: ____________________

CLAIM: ____________________

TO WHOM IT MAY CONCERN:

This authorization or photocopy hereof, which is unlimited as to time, will authorize you to release to The Beacon Mutual Insurance Company and their appointed representatives all information you may have regarding my condition past and present while under your observation or treatment, including but not limited to: history obtained, x-ray and physical findings, diagnosis and prognosis.

Print Name: ____________________

(As it appears on your Social Security card)

SIGNATURE: ____________________

State Relationship if not Patient: ____________________

Patient's Date of Birth: ____________________

Patient's Social Security #: ____________________

DATE: ____________________

The Beacon Mutual Insurance Company
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Claims: 401.825.2667 | Toll Free: 1.888.886.4450