The Beacon Mutual Insurance Co.

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