

MEDICAL AUTHORIZATION RELEASE FORM

RE: Name:
SSN: xxx-xx-x_____
DOB:

TO: _____

I, _____, hereby authorize _____
_____, who treated me for the time period from _____ through
present, to release any and all records in your custody, including office records, medical reports,
charts, x-rays, and bills concerning my physical or mental condition to Gary Cunha, P.C. and/or
Gary William Cunha, Attorney and Counselor at Law.

The purpose for this release of information is to assist me and my attorney in anticipated or
pending litigation.

A copy of this authorization has the same force and effect as an original. This authority will
remain in effect for a period of Two Years from the date hereon or until I revoke same in writing.

I understand that I have the right to revoke this authorization, except to the extent that
_____ has taken action in reliance thereon, by
providing you with a written request to revoke this authorization.

I understand that information that is disclosed or used under this authorization may be disclosed
by Gary Cunha, P.C./Gary William Cunha and no longer protected by the privacy provisions of the
Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Section 164.508(c).

Signed on _____, 201__.

Print: