MEDICAL AUTHORIZATION

TO WHOM IT MAY CONCERN:

I, _____

hereby authorize the release of all medical documentation and other information which may be in the possession of any insurer, physician, surgeon, hospital, ambulance service or nurse, to any representative of Halifax Mutual Insurance Company

(hereinafter called "The Company") regarding my injuries, medical history, and physical & mental condition both prior to and subsequent to the date of this authorization, regardless of lapsed time.

Upon presentation of this authorization (or a photocopy), you are authorized to release a copy of these records to any representative of The Company. I understand that information disclosed pursuant this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

The purpose of the disclosure is at my request and this Medical Authorization shall be deemed to comply with the requirements of the Health Insurance Portability and Accountability Act (45 CFR § 164.508).

This Medical Authorization shall expire upon final resolution of my pending claim with The Company. I understand that I may revoke this Medical Authorization at any time by sending written notice to the medical providers and to The Company.

WITNESS(ES):

_____
Witness

_____
Witness

_____
Claim Number

SIGNATURE:

_____
Signature

_____
Social Security Number

_____
Date