HUNTER
McCORQUODALE
INSIGHT • INNOVATION • INTEGRITY

Authorization for Medical Information

To Whom It May Concern:

Name of Proposed Insured: _____

Date of birth: _____

I hereby authorize any physician, medical or health practitioner, hospital, clinic or medically related facility or insurance company that has any records or knowledge of me or my health to provide any such information to Hunter McCorquodale. I understand that the purpose of this authorization is to allow determination of eligibility for insurance. Any information obtained pursuant to this authorization will not be disclosed to any other party EXCEPT persons or organizations performing business or legal services in connection with my application, OR as may be otherwise lawfully required or as I may further authorize. A photocopy or faxed copy of this authorization shall be as valid as the original.

Physician Information:

Name: _____

Address: _____

Telephone No: (____)_____

Fax No: (____)_____

Signed at _____ this _____ day of _____, _____

Signature of Proposed Insured _____

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