



## **AUTHORIZATION TO OBTAIN MEDICAL INFORMATION**

I, the undersigned, authorize any physician, physician's assistant or nurse who has attended me, or any hospital at which I have been confined, to furnish to any authorized representative of CORVEL CORPORATION, any and all information which may be requested regarding my condition and/or treatment, and to allow them to examine and copy any radiographic pictures taken of me, or records regarding my condition or treatment. I specifically authorize said physicians, nurses and hospitals to communicate information by any reasonable means, including written or telephonic communication or by direct interview, whether or not I am present during or notified of such communications, and I authorize, to initiate and conduct such communications whether or not I am present or have notice thereof.

A photostatic or faxed copy of this waiver is to be given the same force and effect as the original.

Signature: \_\_\_\_\_  
Address: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name Here

Witness