

REQUEST FOR MEDICAL INFORMATION

DATE: _____ POLICY NUMBER: _____

INSURED'S NAME: _____

AUTHORIZATION

I hereby authorize _____ to:
(Insurance Company Name)

_____ Provide the reasons for the rated policy

_____ Release medical information to me

_____ Release lab results to me

_____ Release medical information and lab results to
the designated medical professional below

Name and address of person to whom medical information should be sent:

This authorization will expire six months after receipt by CPS Insurance Services.

DATE: _____ SIGNATURE: _____

CPS Ron Viola Insurance Services, Inc.
PO Box 6250
Los Osos, Ca 93412-6250
800-640-7770