

# 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 INSURANCE SERVICES  
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