AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

To: _____

_____

_____

_____

I hereby authorize you to release to the law offices of **O'CONNOR, MIKITA AND DAVIDSON, LLC, 8035 Hosbrook Road, Suite 200, Cincinnati, Ohio 45236**, any and all information and/or opinions, including bills, regarding my physical and/or mental condition and treatment rendered while a patient for injuries sustained on _____.

You are further requested to disclose no information to any insurance adjuster or any other persons, without written authority from me to do so, pursuant to privilege and confidential communications statutes. ALL OTHER AUTHORIZATIONS ARE HEREBY CANCELLED. A reproduction of this authorization may be used in place of the original.

Date_____ X _____
Patient

Witness_____

Form-09.doc

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