



CCMSI™

MEDICAL & COMMUNICATION AUTHORIZATION

Date: _____

Claim number: _____

Date of birth: _____

Patient Name: _____

Solely to assist Cannon Cochran Management Services, Inc. in administering an insurance claim, I hereby authorize any physician, hospital, pharmacy, employer or other person or organization possessing non-medical and medical information concerning my claim to permit Cannon Cochran Management Services, Inc. or its representative to view, copy, be given details of all such non-medical and medical information including drug, alcohol, or psychiatric treatment and/or testing. I also agree that any and all of my health care providers may fax my medical records and discuss the details of my medical information, related to the claim, with the representatives of Cannon Cochran Management Services, Inc.

Upon presentation of this authorization, or photocopy of it, I give permission for personal review or photocopying of the information by any representative of Cannon Cochran Management Services, Inc. This release shall remain valid for the length of my claim or unless it is revoked by me in writing.

I, as the patient or authorized signature, understand that a copy of this authorization will be furnished upon request.

THIS IS NOT A RELEASE OF CLAIM FOR DAMAGES.

Signature of Patient

Social Security Number of Patient

Date