GULF COAST
REHABILITATION SERVICES, INC.

RE: NAME: SSN: DOB:

General Release of Information

This release hereby authorizes a representative of Gulf Coast Rehabilitation Inc., to speak with and obtain information from my treating physicians or other health care providers about my past and future medical and/or psychological care needs/services, including obtaining copies of my medical records, for the purpose of completing a future medical cost projection and/or Medicare Set-Aside cost projection.

Contact may also be made with the insurance carrier, program, plan or entity and/or it's representative responsible for funding any potential settlement, life companies for the purpose of obtaining a rated age, a professional administrator involved in administration of a Medicare Set-Aside account or medical custodial account or Trust, a structured settlement broker involved in structured funding of the Medicare Set-Aside account or medical custodial account or Trust, the Social Security Administration and the Centers for Medicare and Medicaid Services to obtain confirmation of my entitlement status to SSDI and Medicare and to ascertain Medicare claim payment information .

I understand that information used or disclosed may be subject to re-disclosure by the entity receiving it and would then no longer be protected by federal privacy regulations.

I may revoke this authorization at any time by notifying Gulf Coast Rehabilitation Inc. in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. This authorization shall expire when all future medical cost projections and/or Medicare Set-Aside cost projections have been completed.

I agree that a Photostat copy of this authorization shall be considered as effective and valid as the original.

PRINT NAME: _____

*SIGNATURE: _____

DATE: _____

* If this Authorization is signed by a legal representative of the individual, a description of such representative's authority to act for the individual must also be provided.

NOTE: A copy of this signed form must be given to the individual signing the document.

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