

**Evergreen Family Health Partners  
Motor Vehicle Accident Authorization  
for Medical Record Release**

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_ Patient Social Security No. \_\_\_\_\_

Date of Accident \_\_\_\_\_ Brief Description of Accident \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**WE DO NOT BILL AUTO INSURANCES.**

**PAYMENT IN FULL IS EXPECTED AT TIME OF SERVICE TODAY.**

\_\_\_\_\_  
  
I authorize Evergreen Family Health Partners to release medical reports related to my injury to the Insurance Carrier. In the event that the Motor Vehicle Accident Insurance Carrier denies the claim for injury, I hereby agree to pay Evergreen Family Health Partners the usual and customary fees for services rendered. If I choose not to pursue a claim with an Insurance Carrier, I also hereby agree to pay Evergreen Family Health Partners the usual and customary fees for services rendered.

**AUTHORIZED SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_