MARK W. HINMAN, M.D.
1350 Tulip Street
Longmont, CO 80501
303-776-6872

I _____, Claim # _____

hereby authorize _____ to reimburse

Mark W. Hinman, M.D., LLC for my medical claim(s) on _____

to _____.

These claim(s) resulted from the Workman's Comp. accident I was

involved in on _____.

I also authorize the office of Mark W. Hinman, M.D., LLC to release the

medical records and claim form(s) to _____

pertaining to the date(s) of service listed above.

_____

Print Name_____

Date_____