AUTHORIZATION and REQUEST for RELEASE of MEDICAL INFORMATION

Dear

This is to AUTHORIZE and REQUEST you to furnish to:

Woodruff Family Law Group
420 West Market Street
Greensboro, NC 27401

Or any representative of that firm, any and all information or opinions regarding _____ physical condition, specifically including the following checked particulars:

( )	history give to you	( )	treatment rendered
( )	prognosis, and your opinion as to any permanent disability	( )	copy of you statement for services rendered

The purpose of the requested disclosure is: (1) to assist my attorneys in evaluating injuries received by your patient; or (2)

This consent is revocable except to the extent that action has been taken in reliance thereupon, and this consent will remain in force for at least three (3) years.

ALL PRIOR AUTHORIZATIONS FOR RELEASE OF MEDICAL INFORMATION ARE HEREBY CANCELLED AND REVOKED.

Very truly yours,

_____

Sworn to and subscribed before me this

The _____ day of _____, 2000.

_____
Notary Public