Baker Benefits Administrators, Inc.

5022 Holly Rd. Suite 102
Corpus Christi, TX 78411

MEDICAL RELEASE FORM

To Whom It May Concern:

I hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person that has any records or knowledge of me or my family member listed, with reference to health and medical treatment, to give Baker Benefits Administrators, Inc., its Reinsureres or its authorized representative any and all information with reference to health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. A photographic copy of this authorization shall be as valid as the original.

_____

Patient's Name (Please Print)

_____

Name of Attending Physician (Please Print)

_____ _____

Physician Telephone Number (area code) Fax Number (area code)

Patient's Signature _____
Employee's Signature (if patient is a minor)

Date _____