Q3 Business Technology Corp.
Benefit and Compliance Solutions

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MEDICAL RELEASE FORM

Attending Physician(s)

Name(s)	Phone #
_____	_____
_____	_____
_____	_____

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health or that of my family listed on this form to give to Medical Cost Management, Q3 Business Technology Corp, or it's insurers any such information. A photographic copy of this authorization shall be as valid as the original. I hereby certify that the above answers are true and complete to the best of my knowledge.

HIPAA Notice: I authorize the use or disclosure of my individually identifiable health information as described above. This authorization will expire 6 months after date signed below. I may revoke this authorization at any time by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.

Signature _____ Date _____

Printed Name _____ Date of Birth _____