

**ABRAMS LANDAU, Ltd.**  
797 Center Street  
Herndon, VA 20170  
(703) 796-9555 FAX (703) 796-9210

MEDICAL AUTHORIZATION

I, \_\_\_\_\_ (Date of Birth  
\_\_\_\_\_, SSN: \_\_\_\_\_) hereby authorize the release of my  
entire record, including all medical documentation and other information  
which may be in the possession of any physician, insurer, surgeon,  
hospital, ambulance service or nurse, to any representative of Abrams  
Landau Ltd. regarding my injuries, medical history, and physical &  
mental condition from five years prior to \_\_\_\_\_, to the present. I  
understand that the information in my health record may include  
information relating to sexually transmitted disease, acquired  
immunodeficiency syndrome (AIDS), or human immunodeficiency virus  
(HIV). It may also include information about behavioral or mental health  
services and treatment for drug and alcohol abuse.

Upon presentation of this authorization (or a photocopy), you are authorized  
to release a copy of these records to any representative of Abrams Landau  
Ltd. I understand that information disclosed pursuant to this authorization  
may be subject to re-disclosure by the recipient and may no longer be  
protected by the federal confidentiality rules.

The purpose of this disclosure is at my request for purposes of litigation  
and this Medical Authorization shall be deemed to comply with the  
requirements of the Health Insurance Portability and Accountability Act  
(45 CFR 164.508).

This Medical Authorization shall expire upon final resolution of my  
pending claim and / or litigation handled by Abrams Landau Ltd. I  
understand that I may revoke this Medical Authorization at any time by  
sending written notice to the medical providers and to Abrams Landau  
Ltd. I understand that my revocation will not apply to information that  
has already been released in response to this authorization.

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Patient's Signature

Date