



MEDICAL RECORDS

I do hereby authorize SwiftCare Accident & Injury to furnish my attorney, and/or the insurance carrier, with a complete report of my medical examination, treatment, prognosis, etc. (including notes, x-rays, and other medical data, as determined necessary by my treating doctor), relating to any health care treatment in regards to the accident/injury or other contributing incident giving rise to my need for such health services.

PATIENT NAME

FULL ADDRESS

PHONE NUMBER

DATE OF BIRTH

DATE OF INJURY

PLEASE UPLOAD YOUR ID HERE

TYPE OF ACCIDENT

Motor Vehicle

Slip & Fall

On the Job

Other

PRINTED NAME OF PATIENT

SIGNED

DATE

Only fill this part if the patient is less than 18 years old

ON BEHALF OF THE MINOR CHILD(ren)

SIGNED

DATE

By checking this box, you agree to receive text messages from SwiftCare PI. You agree to our **Terms and Conditions** and our **Privacy Policy**.