CONSENT TO MEDICAL TREATMENT

I authorize my physician or such physician assistants and medical assistants as he may employ to perform on me any medical procedures or treatment which they consider appropriate under the circumstances and to continue such treatment from time to time as my physician and/or his assistants may deem advisable. The effect and nature of this treatment, its intimate nature, possible alternative methods of treatment, and the risks of treatment, if any, have been explained to me. No guarantee or assurance has been given by anyone as to the results that may be obtained.

_____
(Patient)

CONSENT TO RELEASE INFORMATION

To the extent reasonable and appropriate to establish liability for payment and to obtain reimbursement, I authorize Workstar Injury Recovery Center, Inc. ("Workstar") to release any requested medical information or records to any person, organization, or agency which may be liable for payment of any portion of Workstar's fees and charges.

I do hereby further authorize Workstar to furnish the attorney that I have retained to represent me for the personal injuries I previously sustained, for which Workstar is now treating me, with any medical information or records pertaining to me. This includes by way or example and not exclusive a full report of the examination, the diagnosis treatment, and the prognosis
reports.

I CERTIFY THAT I HAVE READ THE ABOVE CONSENT FORM IN ITS ENTIRETY. THAT ANY QUESTIONS THAT I HAD ABOUT ITS CONTENT HAVE BEEN ANSWERED TO MY FULL SATISFACTION. AND THAT I FREELY GIVE MY INFORMED CONSENT TO PERFORMANCE OF SUCH MEDICAL SERVICES. AND CONSENT TO RELEASE OF INFORMATION AS ABOVE STATED.

Date: _____ Signed: _____

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