FLORIDA FAMILY TELEHEALTH **TELE-EMC**

Patient Record Release and Letter of Protection

I do hereby authorize Florida Family Telehealth to furnish my attorney as identified below with full report of any medical records and charges pertaining to my treatment. I do hereby authorize said attorney to pay directly to Florida Family Telehealth such sums that may be due and owing for services rendered to me, and to withhold such sums from any settlement, judgement, or verdict which may be paid to you, my attorney or me as the result of the injury for which I have been treated. I also agree to promptly inform Florida Family telehealth if any other attorney represents me, and that this release and letter of protection will be immediately executed with my new attorney, if charges occur. If a new release and letter of protection is not immediately executed upon a change of attorney, I agree that my full charges shall become immediately due and payable. I fully understand that I am directly responsible to Florida Family Telehealth for all charges and bills submitted by Florida Family Telehealth for services rendered to me. This agreement is made solely for additional protection and consideration of waiting for payment; I also understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

DATE OF ACCIDENT: _____

ATTORNEY NAME: _____

PATIENT NAME: _____

PATIENT SIGNATURE: _____