I hereby authorize any medical practitioner, hospital, medical facility, insurance company or any other agency that has medical records or knowledge of me or my dependents listed on this form, to release all such information to The Karis Group for the administration of my need. I authorize a copy of this form to be used in place of the original.

I hereby grant permission to The Karis Group to discuss any and all of my medical bills with any medical provider or related entity. I understand that The Karis Group will maintain the privacy of any information obtained and will not disclose that information to any other person or entity except as necessary to effectuate service or by express written permission from me.

Names of Dependents:

______________________________ ______________________________

______________________________ ______________________________

Name of Participant: **Name of Spouse:**

______________________________ ________________________

Signature **Date** **Signature** **Date**

X_____________________________ _______ X______________________ ______