

3632 Nostrand Avenue, Brooklyn, New York 11229 Tel: (718) 332-4409 Fax: (718) 332-4472

| l, | do hereby, authorize the above |
|---|--|
| mentioned Facili | ty/Medical Service Provider to furnish you, my attorney with a full ropert |
| mayner examinat | ion, diagnosis, treatment, prognosis, etc., of myself in regard to the acciden |
| 011 | in which, I was involved. |
| l hereby a | uthorize and disease |
| Surgery Center or | uthorize and direct you, my attorney, to pay directly to said AFHC Ambulate |
| him for the media | d Brooklyn Bridge Medical Associates, PLLC sums as may be due and owing |
| any other bills the | al services rendered to me both by reason of this accident and by reason of |
| any other bills tha | t are due his office and to withhold such sums from my settlement, judgme |
| or verdict as may | be necessary to adequately protect said above mentioned Facility/Medical |
| Service Provider/ | And I hereby further give a lien on my case to said above mentioned |
| Facility/Medical Se | Prvice Provider against any and all proceeds of any applications at the |
| 77, 00,00, 50 | rivice i rovider against any and an proceeds of any settlement judgment or |
| verdict which may | be paid to you, my attorney, or myself as the result of the injuries for which |
| verdict which may | be paid to you, my attorney, or myself as the result of the injuries for whic or injuries in connection therewith. |
| verdict which may | ervice Provider against any and all proceeds of any settlement judgment or be paid to you, my attorney, or myself as the result of the injuries for which or injuries in connection therewith. |
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| have been treated | be paid to you, my attorney, or myself as the result of the injuries for whic or injuries in connection therewith. rstand that I am directly and fully responsible to said doctor for all medical. |
| have been treated I fully under | be paid to you, my attorney, or myself as the result of the injuries for which or injuries in connection therewith. rstand that I am directly and fully responsible to said doctor for all medical nim for services rendered me and that this agreement is made solely for said |
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