

Claims File Release Authorization

Policy Holder: _____

SSN: _____ File #: _____

To:

Any and all information to include and not limited to named policy holder's claims history, policy coverage, and file notes.

This is my Authorization for Release to:

And the Authorized Agent of: The Echo Company
 P.O. Box 340927 Sacramento CA 95834
 (916) 646-1936 (916) 646-1946 fax
 www.theechocompany.com
 info@theechocompany.com

Signature of Policy Holder: _____

Printed Name of Policy Holder: _____

Date: _____

The above authorization, signed by the present or past insured, authorizes you to deliver or make available for process all claims information for the above named policy holder to the representative named herein. This authorization is to be used in lieu of a Subpoena Duces Tecum requiring a personal appearance by you or the custodian named of record. If you are unwilling to release named record, we will proceed with issue and serve as stated.