

**HOSPITAL) PERMISSION SLIP  
DOCTOR )**

**To:**

Claimant :  
Insured :  
Date of Acc. :  
Claim No. :

Permission is granted to furnish A.I.M. Mutual Insurance Cos. and their authorized agents or representatives, as well as the above named insured/employer, with a copy of my record of treatment rendered from \_\_\_\_\_.

A.I.M. Mutual Insurance Cos. will be responsible for payment of your usual charge for such a copy.

You are authorized to permit the examining physician for A.I.M. Mutual Insurance Cos. to examine any x-ray or films you may have concerning my condition.

My permission is also given for you to accept a photocopy of this authorization.

\_\_\_\_\_  
*(Signature)*

\_\_\_\_\_  
*(Social Security Number)*

\_\_\_\_\_  
*(Date of Birth)*

\_\_\_\_\_  
*(Date)*

**Send Record to:**

**A.I.M. Mutual Insurance Cos.  
P.O. Box 4070  
Burlington, MA 01803-0970**

AIM Cos01 11/08