A.I.M. Mutual Insurance Company
Massachusetts Employers Insurance Company
New Hampshire Employers Insurance Company
Associated Employers Insurance Company

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

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)

_____
(Date of Birth)

_____
(Date)

Send Record to:

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

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