MRIhealthgroup
2727 West Paces Ferry Rd. SE Bldg One Suite 750 | Atlanta, GA 30339 | PH: 770.702.0909 | FAX: 800.467.1066 |
| SUPPORT@MRIHEALTHGROUP.COM |

Medical Lien Finance
Medical Lien / Letter or Protection

Date:_____

I _____(Client/Patient) authorize and direct the below named attorney to pay MRIhealthgroup the agreed amount out of my share of any collection made on my behalf against and party liable for the injuries requiring medical treatment by GA Health Imaging.

Should the below named attorney not agree to signing this letter of protection, MRIhealthgroup may revoke this letter of protection by providing written notice to both the attorney and patient and MRIhealthgroup may then actively pursue collection of the account or accounts in its normal manner.

I hereby authorize and direct my attorney to cooperate with MRIhealthgroup when/if they inquire concerning the status of any claim or suit on my/our behalf, and such advice shall be for my account and without charge or cost to MRIhealthgroup.

_____ _____

Client's Printed Name Signature Date

_____ _____

Attorney Name Signature Date