Medical Applications Corporation
30851 Agoura Road, Suite 107
Agoura Hills, CA 91301

Authorization Form

I, the undersigned, have authority to authorize Avanta and its representatives to perform the following procedure(s) on my system.

Check all that apply:

- ❑ Compress this practice: Name_____ Number:_____
  Up to this date:_____
- ❑ Delete this practice: Name:_____ Number:_____
- ❑ Delete: Provider Name:_____ Number:_____
  From: Practice Name:_____Number:_____
  Any activity for this doctor should be re-assigned to the following provider:
  Name:_____ Number:_____
- ❑ Expand this practice: Name:_____ Number:_____
- ❑ Create New Practice: Name_____ Number:_____
  Copy Practice Files:_____
  _____From Practice Number:_____
- ❑ Copy Practice Security: _____From Practice Number:_____
  Special Instructions:_____
  _____

My signature appears below acknowledging the following:

- My last successful back-up was completed on: _____
- My last successful system maintenance in the above practice(s) was completed on:
  _____
- I have printed hard copies of all that will be deleted or compressed with the understanding that once the procedure is completed, I will no longer have access to the deleted data on the system.

_____ _____ _____

Signature Title Today's Date

_____

Office