

MDA Release

I, _____, give Words +, Inc permission to contact and discuss third party funding issues with MDA (Muscular Dystrophy Association) on my behalf.

_____ **Date**

_____ **Signature of Client**

If Client is unable to sign

Sign client full name _____

Representative signature _____

Relationship to client _____ Representative Name _____

Representative Address _____

City _____ State _____ Zip _____

Reason client unable to sign _____ **Date** _____

Original signature and date are required by Medicare. Please mail back to:
Words+, Inc.
42505 10th Street West
Lancaster, CA 93534