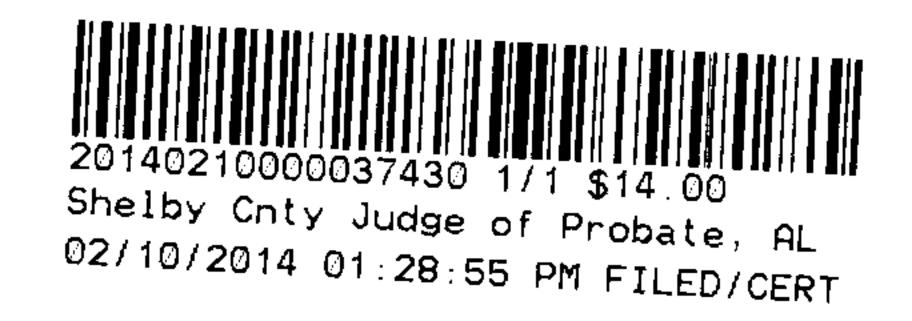
TO: Shelby County Probate Office

P.O. Box 825

Columbiana, AL 35051



NOTICE OF AMENDED HOSPITAL LIEN

Under the provisions of Alabama Code 1975, § 35-11-370 et seq., notice is hereby given that Health Care Authority of the Baptist Health Foundation, Inc., whose address is 1000 1st Street North Alabaster, AL 35007, claims a lien for all reasonable charges for hospital care, treatment and maintenance necessitated by injuries received by:

Patient's Na	ame: Erika Sip	an		
Address:	•	yler Circle		
Audi Css.		ana, AL 35226		
Admit Date				
Discharge l				
Amount Du	ue: \$1,189.00)		
	t's knowledge, the names and tive of said person, to be liab			·
State Farm - 01.	3 96Н 613			
P. O. Box 10614	5			
Atlanta, GA 30)348-6145			
State Farm Insu	ırance - 013T22565			
P O Box 106151				
Atlanta, GA 30)348			
			Shelby Baptist Medica	al Center
CTATE OF MICCICCIDDI		BY:		
STATE OF MISSISSIPPI				
COUNTY OF ALCORN			Agent	
The foregoing statement were foregoing statement were provider for and on behalf		ed before me thisShelby Baptist Medical	h day of Feb Center of the above named	_, 2014, by I health care
MY COMMISSION EXPI	- KARY P	UB(CO.	RY PUBLIC Tool	rell museran
	MISCHELL M	WILBANKS		
	Commissi Dec.	on Expires		
	COR	N.CO.		