AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

NAME OF EMPLOYEE:

NAME OF EMPLOYER:

NAME OF ATTORNEY/LAW FIRM:

DATE OF ACCIDENT:

I hereby authorize and consent for the above named employer to disclose to my attorney referenced above, or to his duly authorized agent or representative, copies of the following:

l. Copies of all records of any nature which reflect all dates and hours I missed from work as a result of injuries I suffered in an accident on the date referenced above.

2. Copies of all documents which reflect my hourly rate for the dates and hours missed from work as identified in paragraph 1 above.

The cost of copying such records shall be paid by my attorney.

In furtherance of this Authorization, I hereby waive all provisions of law and privileges relating to the disclosure hereby authorized.

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 (date)