CLIENT AUTHORIZATION

This Authorization authorizes the release of Protected Health Information pursuant to 45 CFR Parts 160 and 164.

TO: _____

OUR CLIENT: _____

DATE OF LOSS: _____

SOC. SECURITY #: _____ DATE OF BIRTH: _____

COMPANY TO RECEIVE REQUESTED INFORMATION:

WALSH & FRIEDMAN, LTD.
400 South Maryland Parkway
Las Vegas, Nevada 89101
(702) 474-4660 – Telephone
(702) 474-4664 – Facsimile

The undersigned hereby authorizes the above law office or their representative to review, inspect, copy, photocopy, and/or receive in your possession or control pertaining to the undersigned person and relative employment, wage records and/or medical records as indicated by an (X) below:

_____ Medical reports, records, charges, notes and statement;

_____ X-rays, films and reports;

_____ Personnel, employment and wage records;

_____ School transcripts and attendance records;

_____ Police accident reports, arrest records; or

_____ Other_____

A PHOTOCOPY OF THIS AUTHORIZATION WILL BE CONSIDERED AS VALID AS THE ORIGINAL

_____ _____
CLIENT SIGNATURE *DATE*

_____
PRINT NAME

THIS AUTHORIZATION SHALL EXPIRE ONE (1) YEAR FROM THE DATE THIS AUTHORIZATION IS SIGNED, OR AT THE END OF THE LITIGATION, WHICHEVER IS LAST TO OCCUR. THIS DISCLOSURE IS MADE AT THE PATIENT'S/CLIENT'S REQUEST FOR THE PURPOSE OF LITIGATION. THE PATIENT/CLIENT ACKNOWLEDGES THAT THEY HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME.