

THE DOMINGUEZ FIRM LLP



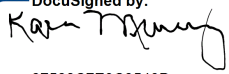
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

TO: _____

I hereby authorize THE DOMINGUEZ FIRM, LLP, or its authorized representative to review, inspect, and make copies, including photostatic copies, of any and all medical and hospital records and reports, employment and/or wage and personnel records, and police reports of any kind whatsoever, pertaining to my healthcare treatment, employment, and automobile accident, in your possession, custody or control. I further authorize the use of the herein requested records by the requesting party for any purposes prescribed by law.

I AM WILLING THAT A PHOTOSTATIC COPY OF THIS SIGNED AUTHORIZATION BE CONSIDERED AS VALID AS THE ORIGINAL.

EXECUTED THIS _____ DAY OF _____
(MONTH) (YEAR)

DocuSigned by:

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Signature of patient/employee/client

Signature other than Patient

Relationship of Patient

Authorization valid to: _____
(Date)