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:

_____
87588C7E0C9540D...

Signature of patient/employee/client

_____ _____

Signature other than Patient Relationship of Patient

Authorization valid to: _____

(Date)

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