THE LAW OFFICE OF GRANT SKOLNICK

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CLIENT AUTHORIZATIONS

I have retained The Law Office of Grant Skolnick for legal representation with regard to my accident. As part of case representation, I have granted the following authorizations:

> **MEDICAL INFORMATION.** The recipient is authorized to release all medical information requested by GRANT SKOLNICK, including those medical records containing information concerning drugs, mental health, alcohol or HIV.
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> **POWER OF ATTORNEY.** I, the undersigned, of Palm Beach County, FL, do hereby make, constitute and appoint my attorney, GRANT SKOLNICK, as my true and lawful Attorney-In-Fact for me and in my name, place and stead, and on my behalf, and for my use and benefits to sign my name on a draft or check or other documents necessary for the administration/conclusion of my auto accident case.
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> **EMPLOYMENT AND EARNINGS INFORMATION.** GRANT SKOLNICK is authorized to obtain my entire personnel file and all employee and wage records from my present employer and all of my past employers.
>
> **TAX INFORMATION.** I hereby grant my power of attorney to GRANT SKOLNICK to execute request forms for copies of tax information from the Internal Revenue Service and state and local taxing authorities.
>
> **VISITATION.** I authorize any representative of GRANT SKOLNICK to visit me at any health care facility for the purpose of taking photographs or otherwise consulting with me. It is understood that visitations are not to hamper or conflict with needed medical treatment.

A copy of the signed original of this document shall have the same validity as the original. I will appreciate your cooperation with my attorney. Thank you.

__________________________ __________________________
(Name) (Date)

__________________________ __________________________
(Social Security Number) (Signature)

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(Date of Birth)