THE
GRAHAM LAW FIRM

**191 Roswell Street**
**Suite 200**
**Marietta, GA 30060**
**404-526-9955**

**315 West Solomon Street**
**Suite 140**
**Griffin, GA 30223**
**678-603-1119**

AUTHORIZATION TO DISCLOSE
PERSONNEL & WAGE INFORMATION

Client Name: ______________________ Date of Birth: ___________________

S.S.N.: ________________________

1. I authorize the use or disclosure of the above named individual's personnel and wage information as described below:
2. The following individual or organization is authorized to make the disclosure:

Name:_____________________________________________________________________

Address:___________________________________________________________________

3. The type and amount of information to be used or disclosed is as follows:

___ Evaluations

___ Awards

___ Disciplinary actions

___ Pay raises and/or bonuses

___ Wage or salary

___ Other _________________________________________________________________

4. I understand that the information in my records may include personal information.
5. This information may be disclosed to and used by the following individual or organization:

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for the purpose of: __________***PERSONAL INJURY CLAIM***___________.

6. I understand I have the right to revoke this Authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the human resources department. I understand the revocation will not apply to information that has already been released in response to this Authorization. Unless otherwise revoked, this Authorization will expire at the conclusion of my personal injury claim, whether by settlement or litigation. If I fail to specify an expiration date, event or condition, this Authorization will expire in six (6) months.
7. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this Authorization.

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|---|---|
| ___________________________________ | ______________________________ |
| Signature of Client or Legal Representative | Date |
| ___________________________________ | ______________________________ |
| If signed by Legal Representative<br>Relationship to Patient | Signature of Witness |