WAGE AUTHORIZATION

I authorize Employer:_____
Address: _____

and any other firm or employer by whom I am, or by whom I have been employed, to furnish the Law Office of William T. Wilson all information in their possession regarding my position, the nature of my work, wages, hours and time lost, both before and after the accident of _____.

I further authorize these firms or employers to release all information related to amounts paid or due under any sick leave plan, wage continuance plan or group hospital or accident benefit plan, including the identity of the insurance carrier.

This information will be used for pertinent legal purposes, including the verification, evaluation, and negotiation of the employee's claim.

THIS AUTHORIZATION SHALL REMAIN VALID UNLESS REVOKED IN WRITING WITH NOTICE TO THE LAW OFFICE OF WILLIAM T. WILSON, EITHER FOR ONE YEAR FROM THE DATE SIGNED OR THE DATE A CLAIM HAS BEEN LEGALLY CONCLUDED, WHICHEVER OCCURS FIRST.

Upon presentation of this authorization, or a photocopy of it, you are directed to permit the personal review or photocopying of the information by the Law Office of William T. Wilson.

I, as the employee or authorized signatory, understand that a copy of this authorization will be furnished upon request.

_____ _____
(Signature) (Date)

_____
Typed/Printed Name

_____/_____/_____
(Social Security Number)

_____
(Date of Birth)