THE OFFICE OF DOCTORS:

KATHLEEN SAVAGE & KEVIN PELTON

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SUITE 2200
LOS ANGELES, CA 90033

PHONE: (323) 264-7600 FAX: (323) 261-8027

I Hereby authorize ____________________ to furnish to any and all of my medical records and related information pertaining to my care and treatment as the result of my injury, illness, and/or claim benefits. The medical records and related information includes, but is not limited to, medical histories, reports, charts, notes, letters, x-rays, films, MRI's, CT scans and reports, itemized bills with treatment codes, insurance and claim records, correspondence, payment, consultations, examinations, prescriptions, diagnosis, tests, and treatments.

This authorization expires one year from the date of this authorization or the date that my claim is finally closed, whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction. A photocopy of this authorization shall have the same validity as the original.

Sign: ____________________________ **Date:** ____________

Name: ____

Address: ____

Telephone: ______________________ **SSN#** __________

Representative (if applicable): _____________________________