



POLARIS INJURY LAW
ATTORNEYS
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GENERAL AUTHORIZATION FOR RELEASE OF INFORMATION

RE: (Name)

TO WHOM IT MAY CONCERN:

The undersigned does hereby certify that LINGENBRINK CAZARES INJURY LAW, PS is the undersigned's attorneys of record. I have authorized my attorneys, or representatives of their office, to obtain any information regarding me and I acknowledge such authorization as follows:

1. **EXTENT OF AUTHORIZATION.** This authorization and release shall apply to myself, or to the person whose name appears above, any child of mine, or for any person for whom I am responsible for their care, custody and control. All provisions of this authorization shall apply to such persons.
2. **NATURE OF INFORMATION.** I hereby authorize any person to provide my attorneys all information requested by them, including but not limited to school records (which shall be deemed to include personnel files, teacher evaluations, intelligence or psychological testing, school medical information or other confidential information), and past or present employment records.
3. **DURATION.** This authorization shall remain in effect for a period of 90 days, or until my written revocation, which ever occurs first.
4. **COPY IN LIEU OF ORIGINAL.** A copy of this signed original authorization shall have the same force and effect as the original.
5. **REASON FOR RELEASE.** No reason need be given by attorneys for the requested release of any information.

REVOCAION OF PRIOR RELEASES. I hereby revoke all previous authorizations and releases previously supplied to you, or which may have been provided to any other person prior to your receipt of this authorization.

Dated _____

Full Name _____

Parent/Guardian