

PRIVACY ACT AUTHORIZATION AND WAIVER

I, _____, authorize the U.S. Department of Labor's Office of Workers' Compensation Programs to disclose to the following recipient individuals and/or entities:

Legal-Ease Digital Imaging LLC

any and all information regarding my claim for compensation filed under the Federal Employees' Compensation Act, OWCP File Number:

Mailing address(es) for the recipients who will receive the records:

2496 Meadowcroft Dr Burton, MI 48519

Phone: 855-534-4003

Fax: 810-547-4030

Email address(es) for the recipient who will receive the records:

pat.legalease@gmail.com

This authorization is effective on the date it is signed and is effective for 365 days from the date of the signature below.

A copy of this authorization shall have the same force and effect as the signed original.

Signature of Claimant

Name of Claimant

Address of Claimant

Date: _____