AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To the following health care provider
("Authorized Provider")

Re: Patient name:
Date of Birth:
Patient SSN:

The undersigned issues this Authorization pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. §164.508 ("HIPAA"), and the California Confidentiality of Medical Information Act, Cal. Civ.C. §56 ("CCMIA"), as each may be amended from time to time, and the rules and regulations promulgated thereunder. This Authorization covers information or material whose disclosure would, but for this waiver, be otherwise prohibited by state and federal statutes or regulations.

1. **Persons Authorized to Receive Medical Information.**

The undersigned hereby authorizes the release of Medical Information, as defined in Section 2 below, to the following person(s) ("Authorized Recipient(s)"):

Martin I. Aarons
The Aarons Law Firm, APC
15250 Ventura Blvd., Suite 505
Sherman Oaks, CA 91403

2. **Medical Information Authorized for Release.**

"Medical Information" comprises any information, verbal or written – including, but not limited to, any medical and hospital records, documents, reports, X-rays or other films, photographs, billings, studies or correspondence relating to treatment, examination and/or hospitalization – regarding any past, present or future physical or mental health conditions, including all information relating to the diagnosis and treatment of HIV/AIDS (Health and Safety Code §120980(g)), sexually transmitted diseases, mental illness (Welfare and Institutions Code §§5328, et seq.), drug or alcohol abuse (42 C.F.R. §§2.34 and 2.35), and genetic testing information (Health and Safety Code §124980(j)).Other Medical Information includes:

- Discharge Summaries
- Billing Statements
- Pathology Reports
- EKGs
- Progress Notes
- Vaccinations / Immunizations
- Laboratory Reports
- Dental Records
- Operative Reports
- Radiology Reports
- Emergency Medicine Reports
- History & Physical Exams
- Diagnostic Imaging Reports
- Consultations
- Outpatient Clinic Records

3. **Specific Uses and Limitations.**

Authorized Recipient shall specifically use, and is limited to specifically using, the Medical Information for the following purpose ("Specific Use"):

To provide legal representation to the undersigned in connection with legal claims relating to my injuries, benefits or other related matters.

4. **Health Care Providers Authorized to Release Medical Information.**

This Authorization applies only to the Authorized Provider named above.

5. **Expiration of Authorization.**

Unless otherwise revoked, this Authorization expires upon the occurrence of the following:

Date on which Authorized Recipient's legal representation of the undersigned is concluded or earlier terminated by substitution of counsel, withdrawal of counsel, or otherwise.If no date or event is indicated in the space immediately above, this Authorization will expire 12 months after the date of signing this Authorization.

6. **Other Required Statements.**

a. Right to Revoke. The undersigned is aware that he or she may revoke this Authorization at any time, provided that he or she does so in writing and submits it to the Authorized Provider. The revocation will take effect when the Authorized Provider receives it, except to the extent that the Authorized Provider or others have already taken action in reliance on this Authorization.

b. Potential Redisclosure. Authorized Provider and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep the undersigned's health information confidential. The undersigned is aware that authorized disclosure of Medical Information to someone who is not legally required to keep it confidential may result in loss of protection under state or federal health information confidentiality laws.

c. Right to Receive Copy. The undersigned is aware that he or she has a right to receive a copy of this Authorization. A reproduced copy of this Authorization shall be as valid as the original.

d. Voluntary Authorization. The undersigned affirms that this Authorization is voluntary and freely given.

Date:

Very truly yours,

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The Aarons Law Firm
A Professional Corporation

15250 Ventura Boulevard, Suite 505 818-794-9250 (tel)
Sherman Oaks, CA 91403 818-302-2072 (fax)
www.aaronslawfirm.com maarons@aaronslawfirm.com

March 28, 2012

VIA US MAIL

Latino Family Media, Inc.
2627 Manhattan Beach Blvd., Suite 200
Redondo Beach, CA 90278

Re: Your former employee Paul Ashen

To Whom it May Concern:

My office represents Mr. Ashen regarding the outstanding wages due to him from his employment with Latino Family Media, Inc.

Mr. Ashen is requesting a copy of his personnel file, including the following:

- All documents he signed relating to obtaining and retaining employment with you, pursuant to California *Labor Code* § 432.
- All wage statements pursuant to California *Labor Code* § 226(b);
- All personnel file documents including those related to his performance and any grievances concerning him, pursuant to California *Labor Code* § 1198.5.

I have included an authorization for those documents to be released to my office.

Thank you in advance for your prompt attention to this request. If you have any questions, please give me a call.

Very truly yours,

The Aarons Law Firm
A Professional Corporation

Martin I. Aarons

Enclosure as indicated