

D I A Z L A W F I R M



ATTORNEYS AT LAW

CLAIMANT AUTHORIZATION FORM

A. Claimant Information

Full name: _____

Street/P.O Box: _____

City: _____ State: _____ Zip Code: _____

Social Security number: _____--____--_____

B. Attorney Information

Attorney name: **Gerald J. Diaz, Jr.**

Law firm name: **Diaz Law Firm**

Street: **208 Waterford Square., Ste. 300**

City: **Madison** State: **MS** Zip Code: **39110**

C. Signature

By my signature, I advise the Court supervised claim program that the Attorney identified in Section B. hereof, "Attorney Information," is authorized by me to act on my behalf concerning my claim(s) with the claim program, and is authorized by me to receive from the claim program, either via wire to the Attorney's IOLTA or other similar trust account or via check made payable to my Attorney, any payments that may be issued to me in connection with my claim(s).

Claimant Signature

_____/_____/_____
Date