AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION

I hereby authorize _____ to use or disclose the following protected health information (PHI) from the medical records of the patient listed below, **for purposes of my Social Security Disability claim**, to:

Requestor Name: The Law Offices of Benjamin Misko, LLC
Requestor Address: P.O. Box 19390, New Orleans, LA 70179

Patient Name: _____

Patient DOB: _____

Patient Social Security Number: _____ - _____ - _____

Patient Address: _____

_____

Disclose the following PHI for treatment dates _____ to present: Any and all medical records including the Entire Chart; Abstract/Pertinent; History & Physical; Discharge Summary; Consult; Operative Report; Progress Notes; Physician Orders; Nurses Notes; ER Report; and Lab; X-ray, prescriptions, psychiatric or psychological evaluations, CT scans, MRI's, EMG, xray, MRI, CT and any other diagnostic films as well as billing records.

The above information is disclosed for **purposes related to my Social Security Claim**.

I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV or genetic information.

This authorization shall expire in : two years ** If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to My Attorney, Ben Misko. I understand that the revocation will not apply to information that has already been released to this authorization.

The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected. Permission is further granted to honor a photostatic copy of this authorization. I may refuse to sign this authorization and it is strictly voluntary. I have the right to receive a copy of this form after I execute it.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____
Signature of Patient/Legal Representative Date
If signed by legal representative, relationship to patient: _____