AUTHORIZATION FOR RELEASE OF INFORMATION

TO: _____

I hereby authorize the above-named source to disclose any information requested concerning me to my attorney, Jonathan C. Ginsberg or Jodi Brenner Ginsberg, of Ginsberg Law Offices (hereinafter referred to as "attorney"), and to provide my attorney with any and all records concerning me, including, but not limited to, the following:

MEDICAL RECORDS: Hospital or other medical records, office notes, x-ray results, laboratory records and reports, hospital intake records, tests of any type or character, and all records that pertain to hospital or other medical history, condition, treatment, diagnosis, prognosis, etiology or expense.

BILLS FOR MEDICAL TREATMENT: All medical and/or hospital bills, accounts, receipts or other financial statements concerning my financial account with your office/hospital for medical treatment rendered to me.

EMPLOYMENT INFORMATION: All information from any employer or other person having such information regarding wages or salary, nature, duration, terms, and evaluations of employment, including all information contained in my personnel, medical or workers' compensation file.

GOVERNMENT RECORDS: All government records, including any Veterans Administration records regarding my service, my physical or mental condition, or other information as set forth above.

SPECIAL AUTHORIZATION

In addition to the above stated records, I specifically authorize my attorneys to access any records or information concerning any condition from which I may suffer, including psychological or psychiatric illness, substance abuse, alcoholism, sickle cell anemia, HIV positive or negative status, and AIDS. Initials: _____

My attorneys may use these records for any purpose except as restricted by the Federal Confidentiality rules and by the provider of the records or information.

PERMISSION TO PHOTOGRAPH

In addition, I authorize my attorneys to photograph my person. This permission to take photographs includes the permission to take such photographs while I am present in any hospital or other medical establishment.

INFORMED CONSENT

I understand that these records are being requested to help in my Social Security disability claim. I hereby acknowledge that the doctrine of informed consent has been explained to me, and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of the authorized information. Furthermore, I understand that the Federal Confidentiality rules specifically restrict the use of this information to criminally investigate or prosecute any alcohol or substance abuse patient. I hereby acknowledge that this consent is truly voluntary and is valid until fulfilled. I further acknowledge that I may revoke this consent at any time, except to the extent that action based on this consent has been taken. Unless and until revoked by me or my attorney by notice to you, the above-named provider of records or information, this consent shall be valid for two (2) years from the date of my signature. The patient does not have to sign the authorization as a condition of receiving treatment.

CONFIDENTIALITY

Because such information is confidential to me, you are requested to treat such information as confidential, and you are requested not to furnish any such information, in any form, to anyone other than my attorney or the Social Security Administration without written authorization from me, except for the purpose of collecting any fee due you. Any information obtained by my attorneys will not be released to any other persons or organizations other than for the purposes of aiding me in my Social Security disability claim, unless I so authorize. I hereby revoke all previous authorizations, with the exception of any authorizations I may have executed for the release of information to the Social Security Administration for the purposes of helping in my Social Security disability claim.

Your full cooperation with my attorney is requested. You are authorized and directed to allow inspection of any of the foregoing records and to furnish oral and written reports to my attorneys as requested by them on any of the foregoing matters. I hereby declare that a photocopy of this authorization shall be as valid as an original.

This _____ day of _____, 20_____.

_____
SIGNATURE