

MEDICAL AUTHORIZATION

TO: _____

I, _____, do hereby authorize and directed to permit the examination of, and the copying or reproduction in any manner, whether mechanical, photographic, or otherwise, by any member, agent, or employee of the Law Offices of Michael Sloan, P.O. Box 600, McKinney, Texas 75070, or such other persons as the firm may authorize, including Certified Shorthand Reporters, all or any portions desired by them of the following:

- a. Hospital records, x-rays, x-ray readings and reports, laboratory records and reports, all text of any type and reports thereof, including psychological or psychiatric records, doctor's and nurse' notes, statement of charges, and any and all of my records pertaining to hospitalization, history, condition, treatment, diagnosis, prognosis, etiology or expense;
- b. Medical records, including patient's record cards, x-rays, x-ray readings and reports, laboratory records and reports, all tests of any type and character and reports thereof, statement of charges, and any and all of my records pertaining to medical care, including psychological or psychiatric records, history, condition, treatment, diagnosis, prognosis, etiology or expense.

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

INITIAL _____

You are further authorized and directed to furnish oral and written reports or copies of hospital and medical records described above to said law firm or employee or agent of such law firm, as requested by such person, on any of the foregoing matters.

The purpose of this disclosure is for legal matters relating to my: Social Security case.

This authorization is VALID, ONLY FOR 180 DAYS, from the date below and is withdrawn after that time.

This authorization may be revoked in writing by delivery of such revocation to the Law Offices of Michael Sloan and to the medical provider to whom a request for disclosure has been made.

I hereby acknowledge that information obtained by the Law Offices of Michael Sloan may be subject to redisclosure and no longer protected by the medical provider to whom a request for disclosure has been made.

I hereby further acknowledge that treatment or payment cannot be conditioned on this authorization.

THIS AUTHORIZATION SUPERSEDES ALL PREVIOUS AUTHORIZATIONS AND ANY PREVIOUS AUTHORIZATION IS HEREBY CANCELLED AND SHOULD NOT BE HONORED. A PHOTOSTATIC OR FACSIMILE COPY OF THIS AUTHORIZATION MAY BE ACCEPTED AS THE ORIGINAL HEREOF.

Name of Patient: _____ Date: _____

Date of Birth: _____ Social Security No.: _____

SUBSCRIBED AND SWORN TO before me on _____, 2011.

Notary Public in and for the STATE OF TEXAS

