AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL INFORMATION

Patient Name _____ Birthdate: _____
Social Sec. No: _____ Home Phone: _____
Address: _____

I hereby authorize _____ **to release information to:**
Doctor or Clinic Name

Attorney:	**Deborah L. Hardin**	**Phone**:	501-247-1830
	The Hardin Law Firm, PLC	**Fax:**	501-286-6017
Address:	Post Office Box 5096	**Email**:	TheHardinLawFirm
	Cabot, Arkansas 72023		@gmail.com

Purpose of Requested Use or Disclosure: To Assist with Social Security Disability Claim.

Please Check the Types of Records to Be Released:

☐ **Complete Medical Record**	☐ Consultation	☐ Radiology Reports
☐ **Medical Opinions**	☐ Pathology Report	☐ Radiology Imaging/Images
☐ Operative Report	☐ EKG/EEG	☐ Laboratory Tests/Results
☐ History and Physical	☐ ER Record	☐ Photos
☐ Physician Notes	☐ Verbal Communications	☐ Billing
☐ Discharge Summary	☐ Other _____	

The **treatment dates covered by this authorization** are from: Birth to Present.

I have the right to revoke this authorization in writing, to The Hardin Law Firm, PLC or any specified doctor or clinic, except to the extent that action has already been taken in reliance upon this authorization.

I understand and acknowledge that to the extent the persons or entities identified herein as being authorized to receive my medical information are not healthcare providers or health plans covered by federal health privacy laws, they may re-disclose that information and those laws would no longer protect that disclosed medical information.

I agree to pay any and all fees allowable by law that are incurred by the specified doctor or clinic in complying with this authorization.

This Authorization shall expire within one (1) year from date of signature.

_____Initial if it is your desire that this authorization extend to records of your **future treatment** (after the date of signature) as long as such treatment occurs while this authorization is in effect.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Witness **Date**