GEORGOULIS DISABILITY GROUP

TO: _____

_____

_____

_____

Patients Name:

Address:

DOB:

REQUEST FOR RELEASE OF MEDICAL INFORMATION FOR SOCIAL SECURITY DISABILITY CASE

Below is an authorization for release of medical information recently signed by the above named patient, whom we are representing in a pending Social Security disability case and who ***is indigent and unable to pay***. Please mail only those records indicated below as soon as possible. Please forward this information to us with your bill and we will immediately remit the amount due.

Re-Disclosure Statement: I understand that the information released under this authorization may be re-disclosed by Georgoulis Disability Group, and therefore the addressee and its employees have no responsibility as a result of any re-disclosure; as such, the released information is no longer protected by the Privacy Rule.

Very truly yours,
Georgoulis Disability Group, LLC

I hereby authorize _____ to release copies of my medical records, narrative summary, and/or other information in connection with my treatment during the period of _____to _____ to: Georgoulis Disability Group, 575 E. Big Beaver Rd. Ste 230 Troy, MI 48083 for use in my pending Social Security disability claim. Please do not include any nurse's notes or progress reports. This authorization applies to any information in my medical history, including psychiatric treatment for alcohol and/or drug abuse:

_____ Narrative summary of patient's case, office notes, and assessment of claimant's ability to do work-like activity.

_____ Summary sheet, Discharge Summary and Hospital and Physical

_____ Completion of Physical Capacity Evaluation.

_____ Completion of Mental Status Questionnaire.

_____ Other: _____

This statement must be signed and dated after the date of hospitalization and/or outpatient treatment and may be revoked at any time, except to the extent action has been taken prior to any expressed action to revoke this statement. The validity of this authorization will extend 90 days from the date of the signature. If no action has been taken to process this statement within that time frame, an automatic expiration will be in effect. I understand the nature of the release and freely give my consent.

_____

Claimants Signature Date