COOKE & COMPANY, INC.
Social Security Disability Representation

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Federal Health Insurance and Accountability ACT (HIPPA) Authorization for Use & Disclosure of Protected Health Information

RE:
SSN:
DOB:
CLAIM:

Date: _____
To: _____
_____
_____
_____

Dear _____

You are hereby authorized and requested to furnish my legally recognized disability representative, **Tracy M. Cooke, CDRP, Cooke & Company, Inc. Social Security Disability Representation** any and all information regarding my medical condition, or regarding any injuries or diseases for which I have consulted you or received your service including the nature of the physical or mental impairments, history, contributing factors, complications, prescriptions, x-rays, MRIs, CAT-scans, copies of hospital or other records, estimates of the period or amount of disability, subjective symptoms, diagnosis, prognosis and any other information which may be available to you concerning my medical condition.

This **Authorization for Use and Disclosure of Protected Health Information** is made voluntarily for the sole purpose of obtaining Social Security disability benefits (Title II RSDI, Title XVI SSI or Concurrent) and shall remain effective, unless revoked by me in writing, for one year after the date on which this Authorization is signed. I understand that I have the right to revoke this Authorization at any time. I understand that a revocation will not be effective to the extent that any healthcare provider has already taken requested action in reliance upon this Authorization. I further understand that information disclosed as a result of this Authorization will be subject to re-disclosure to the Social Security Administration, its related agencies and officers, and as such will no longer be protected under the Privacy Rule. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining my Authorization. I understand that any fees or charges associated with this Authorization will comply with all laws and regulations applicable to release of information. I understand that if my medical record contains information relating to Sickle Cell Anemia, genetic testing, HIV infection, AIDS or AIDS-related conditions, alcohol or drug abuse, psychological or psychiatric conditions et al, this Authorization will include that information. I finally understand that a copy of this Authorization will be considered as valid as the original.

_____ _____
Claimant/Patient Address

_____ _____
Tracy M. Cooke, CDRP City & State Zip Code