AUTHORIZATION FOR RELEASE OF MEDICAL AND/OR OTHER RECORDS PURSUANT TO HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA)

I hereby authorize use or disclosure of protected health information or any other protected information about me as described below.

1 . The following specific person or class of persons or facility is authorized to make the requested use or disclosure:

Any physician, dentist, nurse, or other medically trained person, medical provider, hospital, clinic, and/or infirmary as well as any psychiatrist, psychologist, or other mental health provider or other person or entity who provided treatment, examination, diagnosis, prognosis or any other medical, mental, or health service to me. This Release also applies to any marital counselor who provided services to me and my spouse individually or together.

2. The following person or class of persons may receive disclosure of protected health information about me:

His name is: James E. Holmes
Attorney at Law/Guardian ad Litem
His address & Ph No. are: 4133 Briarcliff Road, N.E.
Atlanta, Georgia 30345
404-634-7897

3. The specific information that should be disclosed is:

Any and all records regarding examination, diagnosis, counseling, or treatment of me and billings for such services. I expressly authorize this access, inspection and examination, and copying of any such records regarding me and further authorize you to review and to discuss these records and my treatment with Mr. Holmes.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. Your full cooperation with James E. Holmes is respectfully requested. A photocopy of this Authorization and of my signature thereon shall have the same force and effect as the original. If you have any questions or concerns about this Authorization, please contact me immediately.

5. I may revoke this Authorization by notifying James E. Holmes in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this Authorization cannot be reversed, and my revocations will not affect those actions. I understand that the medical provider to whom this Authorization is furnished may not condition its treatment of me on whether or not I sign the Authorization.

6. This Authorization expires upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: written revocation by me.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Any Photostat copy of this Authorization shall be deemed as valid as if it were the original.

WITNESS my hand this _____ day of _____, 201_.

_____
_____ (Print Full Name)
DOB: _____
SSN: _____
Ph No.: _____

Sworn to and subscribed before me this
___ day of _____, 201_.

_____
Notary Public
My commission expires: _____