PE0636

LAW OFFICES
GALLER & ATKINS
A LIMITED LIABILITY COMPANY
1117 PERIMETER CENTER WEST, Suite W405
ATLANTA, GEORGIA 30338

DAVID E. GALLER
PAMELA I. ATKINS (also admitted in MD & DC)

TELEPHONE (770) 399-2790
FAX (770) 399-2797
TOLL-FREE (800) 936-4878

December 7, 2004

Mr. Darrell Blevins
Freedom of Information Officer
SSA 3-A-6 Operation Building
601 Security Blvd.
Baltimore, MD 21235

RE: Claimant:
SS#:

Dear Mr. Blevins:

I hereby request copies of all working documents from the Appeals Council used to reach a final decision in the matter herein, under the Freedom of Information Act, as amended (5 U.S.C. 552). This includes all analyses, recommendations, memoranda, medical consultants' reports, and minutes of meetings used to consider my client's case. This includes all written, electronically recorded, faxed, or electronically transmitted information, as well as handwritten, typed, electronically or magnetically recorded voice recordings, correspondence, memorandums, electronic mail, telephone messages, notes, and the like. This is a request for complete, unreduced and entire copies of all such documents in your possession, custody or control, or that are obtainable from other sources. Please forward this information as quickly as possible.

Thank you for your time, attention, and assistance.

Very Truly Yours,
GALLER & ATKINS, L.L.C.

PAMELA I. ATKINS
Attorney-at-Law

PIA/dys
Encl.

cc:

DEC 13 2004

AUTHORIZATION FOR RELEASE OF INFORMATION

TO: _____

I hereby authorize the above-named source to disclose any and all information requested concerning me to my attorneys, Galler & Atkins, L.L.C., or their representatives (hereinafter referred to as "attorneys"), and to provide my attorneys with **any and all records concerning me, including, but not limited to, the following:**

MEDICAL RECORDS: Hospital or other medical records, office notes, x-ray results and reports, laboratory records and reports, hospital intake records, tests of any type or character, and all records that pertain to hospital or other medical history, condition, treatment, diagnosis, prognosis, etiology, or expense.

BILLS FOR MEDICAL TREATMENT: All medical and/or hospital bills, accounts, receipts or other financial statements concerning my financial account with your office for medical treatment rendered to me.

EMPLOYMENT INFORMATION: All information from past, present, or future employers, or other persons having such information, regarding my wages or salary, nature and terms of my employment, any special considerations made to me during my employment, evaluations of my work, and time lost from work.

GOVERNMENT RECORDS: All government records, including any Veterans Administration records regarding my service, my physical or mental condition, or other information as set forth above.

INSURANCE INFORMATION: All insurance records, individual policies, binders, assignments, exclusions, including benefits paid, prepaid health plans, group policies, contract holders/vendors, health and benefit plans for short-term and/or long-term disability benefits, salary continuation, and/or any other health benefit program by any insurer and/or employer in the connection with the administration of insurance benefits, or other information as set forth above.

SPECIAL AUTHORIZATION

In addition to the above stated records, I specifically authorize my attorneys to access any records or information concerning any condition from which I may suffer, including psychological or psychiatric illness, substance abuse, alcoholism, sickle cell anemia, HIV positive or negative status, and AIDS.

Initials: _____

My attorneys may use these records for any purpose except as restricted by the Federal Confidentiality rules and by the provider of the records or information.

PERMISSION TO PHOTOGRAPH

In addition, I authorize my attorneys to photograph my person. This permission to take photographs includes the permission to take such photographs while I am present in any hospital or other medical establishment.

INFORMED CONSENT

I hereby acknowledge that the doctrine of informed consent has been explained to me, and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of the authorized information. Furthermore, I understand that the Federal Confidentiality rules specifically restrict the use of this information to criminally investigate or prosecute any alcohol or substance abuse patient. I hereby acknowledge that this consent is truly voluntary and is valid until fulfilled. I further acknowledge that I may revoke this consent at any time, except to the extent that action based on this consent has been taken. Unless and until revoked by me or my attorneys by notice to you, the above-named provider of records or information, this consent shall be valid for (2) years from the date of my signature.

CONFIDENTIALITY

Because such information is confidential to me, you are requested to treat such information as confidential, and you are requested not to furnish any such information, in any form, to anyone other than my attorneys without written authorization from me, except for the purpose of collecting any fee due you. Any information obtained by my attorneys will not be released to any other persons or organizations unless I so authorize. I hereby revoke all previous authorizations.

Your full cooperation with my attorneys is requested. You are authorized and directed to allow inspection of any of the foregoing records and to furnish oral and written reports to my attorneys as requested by them on any of the foregoing matters. **I hereby declare that a photocopy of this authorization shall be as valid as an original.**

This the 6th day of December, 20__

_____
Witness, if signing with an "X"

_____
Guardian (if Applicable)