Timian • Fawcett
ATTORNEYS AT LAW
experience | service | results

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July 17, 2023

Via Email: CS@Healthcare800.com
Dr. Lawrence A Manning, MD

RE: Patient/Client: Remy Nelson
Date of Birth: 06/06/1996
Social Security No.: xxx-xx-5774
Date of Service: 05/30/2023 – Present

Dear Sir/Madam:

This is simply to advise you that my office has been retained by Carlos Marshall to process his claim for the personal injuries he sustained as a result of an accident that occurred on May 30, 2023.

In order to properly handle and evaluate my client's claim, I will need from your hospital a copy of the medical records & itemized bill generated by this patient's treatment received on May 30, 2023 – to the present date.

Enclosed please find a copy of a medical authorization signed by my client which permits me to secure the information requested.

Thanking you in advance for your anticipated cooperation, I am,

Very truly yours,

Alan R. Fawcett

Alan R. Fawcett, Esq.

AF/ayv
Enclosure

HIPAA AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

TO: Dr. Lawrence . Manning, MD DATE: 07/17/2023

This will authorize you to release to Alan Fawcett, Esq. of Timian & Fawcett, LLC or agents thereof, all medical records of whatsoever nature, mental health records, billing statements, radiological films, pathology material, photographs, videos, and other information concerning:

PATIENT: Remy Nelson SSN: xxx-xx-5774 DOB: 06/06/1996

Dates of Service: 05/30/2023 - Present

This will also authorize you to speak to and disclose orally and/or in writing any information relating to diagnosis, care, treatment, prognosis, and opinions with regard to the above-named individual to Timian & Fawcett, LLC, or any agents thereof.

The purpose of this release and disclosure of this information is at the request of the individual.

I understand that I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance thereon. I understand that I may specify a date for the expiration of this authorization, but that it shall expire by law, without my written revocation, one year from the date written below. Revoking this authorization will not have any effect on actions that the health care provider took in reliance on the authorization before the health care provider received notice of the revocation. The information to be disclosed may be protected by law. Information disclosed under this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations. I understand that my ability to receive health care treatment from the health care provider will not be affected if I do not sign this form; however, without my signature, this request to release the information described above will not he honored, The protected health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases (including HIV/AIDS) and/or genetic marker information. These records will be included in the information we will make available to the individual or organization I have identified above.

07/17/2023
Date

Patient (or representative-explain status below)

If the patient is unable to authorize disclosure of this information, the reason is set forth below, and the supporting documentation is attached,

Reason:
*State basis for authority to give consent on patient's behalf: (a) Medical care power of attorney, guardianship, court order or Letter of Administration (copy attached); (b) Relative or person authorized by law (explain relationship or legal authority).

Note to Health Care Providers: This authorization is provided in compliance with HIPAA. Failure to forward the requested information may render a health care provider liable for damages.

A PHOTOCOPY OF THIS AUTHORIZATION MAY BE USED IN LIEU OF THE ORIGINAL