LAW OFFICE
OF
JAMES S. CONNER
2237 FLORIDA STREET, SUITE D
MANDEVILLE, LA 70448

JAMES S. CONNER – Attorney
EVA D. CONNER – Attorney
TELEPHONE: (985) 626-1002
FACSIMILE: (985) 624-8103

TIFFANY CONNER
BRIAN HENLY
KIERSTEN PRITCHETT
Non-Attorney Representatives

April 26, 2018

Ochsner Health and Medical Centers
Medical Records Department
2810 Florida Avenue
Mandeville, LA 70448

RE: **Jeffrey Bodin**

To Whom It May Concern:

Please be advised that I represent the above named client in a claim for **Social Security Disability Benefits**. I have enclosed a Medical Authorization form signed by my client.

Please send me **any** medical records you may have in connection with my client **specifically, those dated from 01/01/2018 to 04/25/2018.**

If records are available electronically, please send them in electronic format to connerdisability@gmail.com. Please note that under the HITECH Act, if records are available electronically, they MUST be provided in an electronic format. You may not bill for paper copies unless the records are **only** available via paper. If electronic copies are available under the HITECH Act, you may not charge more than your labor costs (a flat fee of not more than $6.50 may be requested in lieu of calculating labor costs). *See* 45 CFR 164.524.

Please note that under the HITECH Act, records **MUST** be received within 30 days of this request. Violations of the HITECH Act's requirements are subject to a penalty of $250,000.

If electronic copies are not available, please advise me in advance of any charge in excess of $20.00 for said records. Please note that Act 1241 of the Louisiana Legislature applies in this case and regulates what can be charged for medical records by healthcare providers in Social Security Disability and/or SSI cases.

Thank you for your cooperation in this matter.

Sincerely,

Eva Conner

EDC/AK
Enclosure

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
THE LAW OFFICES OF JAMES S. CONNER

I hereby authorize Ochsner Health + Medical Center Mandeville to disclose the following protected health information (PHI) from the medical records of the patient listed to:

Requestor Name: Law Office of James S. Conner
Requestor Address: 2237 Florida Street, Suite D
Mandeville, LA 70448

Patient Name: Mr. Jeffrey Bodin

Patient DOB: 5/22/1997

Patient SS# 436-95-8926

✓ Entire Chart	___History & Physical	___Discharge Summary	___Consult
___Operative Report(s)	___Progress Notes	___Admit Summary	___Nurses Notes
___ER Report(s)	___Lab	___X-ray/MRI/CT/Bone Scan	___Abstract/Pertinent

✓ Other Specified From: 1-1-18
To: 4-25-18

The above information is disclosed for the purpose of obtaining Social Security Disability Benefits.

- A PHOTOCOPY OF THIS AUTHORIZATION MAY SERVE AS AN ORIGINAL.
- I understand that I have the right to revoke this authorization at any time and must do so in writing to the above facility, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- I understand that I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I have the right to receive a copy of this form after I sign it.
- This authorization shall expire one year from the date on which it was signed or upon the issuing of a favorable Decision for Social Security Disability benefits.

The following information will be released when included in the above information unless you indicated otherwise:

___AIDS or HIV test results
___Psychiatric or Mental Care treatment
___Alcohol, Drug or Substance Abuse treatment
___other (please specify)________________.

I have read the above and authorize the disclosed of this protected health information as stated.

[signature] Signature of Patient/Legal Representative — Date 4/25/18

If signed by legal representative, relationship to patient ____________

[signature] Signature of Witness — Date 4/25/18

Updated 03/2015

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
Mr. Jeffrey Bodin	436-95-8926
Wage Earner (If Different)	Social Security Number

Part I
CLAIMANT'S APPOINTMENT OF REPRESENTATIVE

I appoint this person, Eva Conner - 2237-D Florida St Mandeville LA 70448 Law Ofc James Conner (Name and Address)
to act as my representative in connection with my claim(s) or asserted right(s) under:

☒ Title II (RSDI) ☒ Title XVI (SSI) ☐ Title XVIII (Medicare) ☐ Title VIII (SVB)

This individual may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☒ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☒ I appoint, or I now have, more than one representative. My main representative is Eva Conner
(Name of Principal Representative)

Signature (Claimant)	Address	
[signature]	528 Beau Chene Dr. Mandeville, LA 70471	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date
(985)520-4713		4/25/18

Part II
REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I, Eva Conner, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☒ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.
☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ Yes ☒ No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ Yes ☒ No

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address	
[signature]	2237 Florida Street, Suite D, Mandeville, LA 70448	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date
(985)626-1002	(985)624-8103	4/25/18

Part III
FEE ARRANGEMENT

(Select an option, sign and date this section.)

☒ **I am charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.*

☐ **I am charging a fee but waiving direct payment** of the fee from withheld past-due benefits --I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **I am waiving fees and expenses from the claimant and any auxiliary beneficiaries** --By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ **I am waiving fees from any source** --I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date
[signature]	4/25/18