

HATFIELD & HATFIELD

ATTORNEYS AT LAW

219 W. WASHINGTON STREET

GREENSBORO, NORTH CAROLINA 27401

TELEPHONE (910) 273-0589

FAX (910) 273-9238

KATHRYN K. HATFIELD
JOHN B. HATFIELD, JR.
CYNTHIA A. HATFIELD

NR
10-27-97

October 17, 1997

Department of Veteran Affairs
Service Medical Records Center
P. O. Box 150950
St. Louis, MO 63115

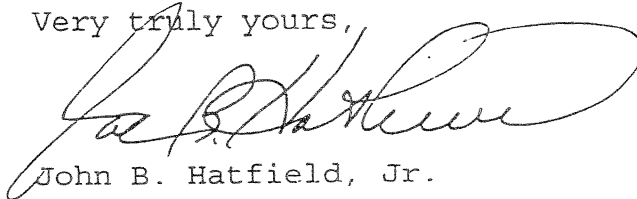
Re: Ronnie Kimble
SSN:
DoB: 01-17-72

To Whom It May Concern:

I represent Ronnie Kimble and hereby request copies of his medical records in your possession. I am enclosing a Release for these records.

Thank you for your assistance in this matter.

Very truly yours,



John B. Hatfield, Jr.

JBHjr/ph
Enclosure

sent
11-25-97
A. Hunter

MEDICAL AUTHORIZATION
PATIENT'S REQUEST FOR CONFIDENTIAL
TREATMENT OF MEDICAL INFORMATION
AND EMPLOYER'S LOSS OF WAGES AUTHORIZATION

TO: Department of Veteran Affairs

RE: Ronnie Kimble

You are hereby authorized and directed to permit the examination of and the copying or reproduction in any manner, whether mechanical, photographic, or otherwise, by my attorney or such other person as he may authorize, all or any portions desired by him of the following:

- a. Hospital records, x-rays, x-ray readings and reports, laboratory records and reports, all tests of any type, character and reports thereof, statement of charges, and any and all of my records pertaining to hospitalization, history, condition, treatment, diagnosis, prognosis, etiology or expense.
- b. Medical records, including patient's record cards, x-ray, x-ray readings and reports, laboratory records and reports, all tests of any type and character and reports thereof, statements of charges, and any and all of my records pertaining to medical care, history, condition, treatment, diagnosis, prognosis, etiology or expense.

You are further authorized and directed to furnish oral and written reports to my attorney, or his delegate, as requested by him on any of the foregoing matters.

By reason of the fact that such information that you have acquired as my physician or surgeon is confidential to me, you are also requested to treat such information as confidential and requested not to furnish any of such information in any form to anyone, without written authorization from me. I hereby revoke any previously dated medical authorization.

I also authorize my attorneys or their delegate to photograph my person while I am present in any hospital.

I further authorize the sending of medical and hospital bills to my attorney, and in the event of recovery by trial or settlement to allow my attorney to withhold an amount sufficient to cover these bills and to make payment directly to you and to deduct the same from any recovery which may be due me.

I further authorize my employer _____ to furnish any and all information requested by my attorney regarding wages or benefits lost by me in regard to the above said matter.

Bonnie Kimble
Client

POA - Kimberly S. Kimble

2016.11.11

Mail letter to receive Honnie Kinble
Medical Records

Dept. of Veterans of Airs
Service Medical Records Center
P.O. Box 150950
St. Louis, MO 63115-8950

SS 

DOB 01-17-72

Corporal when discharged