Take Control *of your* Financial Future

Social Security Disability Advocates
440 East Swedesford Road, Suite 1000
Wayne, PA 19087
(800) 454-4762
Fax: (888) 274-1692

May 25, 2012

Tiffany K Anderson
2 North Avena Avenue
Lodi, CA 95242

Dear Ms Anderson

GENEX Services works with your long-term disability carrier, Unum. After determining you may be eligible for Social Security Disability Insurance benefits Unum referred your case to us. GENEX is a national company that provides a full range of Social Security representation services to applicants like you, throughout the United States.

Our services are available at absolutely no cost to you since Unum pays all our fees. Our knowledge of the Social Security Disability Program and complicated claims process allows us to act on your behalf with minimal, if any, direct contact between you and the Social Security Administration. We know how frustrating the disability application process can be and our services are designed to relieve you of this burden. Please call us today so we can give you more information.

Unum believes you may be eligible for Social Security and encourages you to apply. Your LTD benefits from Unum may be offset by your Social Security Disability award, however, you and your family will gain significant financial advantages such as Medicare health insurance coverage and an extension of COBRA benefits as well as other important benefits. For more information please see the list of enclosed advantages as they are extremely important to you and your family now and in the future.

So that we can begin to help you in the Social Security process, you will need to sign and return the attached forms where highlighted. We have provided a self-addressed stamped envelope for your convenience. As soon as we receive your forms we will call you so we can start the process. It is important that you return the forms quickly to ensure you receive the benefits owed to you as early as possible. We know you will have questions and encourage you to call us at 800-454-4762. We look forward to helping you.

Daniel Lawson

Daniel Lawson
Customer Service Representative

DDL

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
	– –
Wage Earner (If Different)	Social Security Number
	– –

Part I APPOINTMENT OF REPRESENTATIVE

I appoint this person, of GENEX Services, Inc.
(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 Coverage) ☐ Title VIII (SVB)

This person 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 _____
(Name of Principal Representative)

Signature (Claimant)	Address	
Telephone Number (with Area Code) ( ) –	Fax Number (with Area Code) ( ) –	Date

Part II ACCEPTANCE OF APPOINTMENT

I, _____, 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	
	440 E. Swedesford Rd, Wayne PA 19087	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date
(800) 454 - 4762	(888) 274 - 1692	

Part III FEE ARRANGEMENT

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

☐ **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.)*

☒ **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, 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.)*

☐ **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

Form **SSA-1696-U6** (03-2011) ef (03-2011)
Destroy Prior Editions

FILE COPY

INFORMATION FOR CLAIMANTS

DDL

What a Representative May Do

We will work directly with your appointed representative unless he or she asks us to work directly with you. Your representative may:

- get information from your claim(s) file;
- with your permission, designate associates who perform administrative duties (e.g. clerks), partners and/or parties under contractual arrangements (e.g., copying services) to receive information from us on his or her behalf: By signing this form, you are providing your permission for your representative to designate such associates, partners, and/or contractual parties,
- come with you, or for you, to any interview, conference, or hearing you have with us;
- request a reconsideration, hearing, or Appeals Council review; and
- help you and your witnesses prepare for a hearing and question any witnesses.

Also, your representative will receive a copy of the decision(s) we make on your claim(s). We will rely on your representative to tell you about the status of your claim(s), but you still may call or visit us for information.

You and your representative(s) are responsible for giving Social Security accurate information. It is wrong to knowingly and willingly furnish false information. Doing so may result in criminal prosecution.

We usually continue to work with your representative until (1) you notify us in writing that he or she no longer represents you; or (2) your representative tells us that he or she is withdrawing or indicates that his or her services have ended (for example, by filing a fee petition or not pursuing an appeal). We do not continue to work with someone who is suspended or disqualified from representing claimants.

What Your Representative(s) May Charge

Each representative you appoint can ask for a fee. To charge you a fee for services, your representative must get our approval. (Even when someone else will pay the fee for you, for example, an insurance company, your representative usually must get our approval.) One way is to file a fee petition. The other way is to file a fee agreement with us. In either case, your representative cannot charge you more than the fee amount we approve. If he or she does, promptly report this to your Social Security office.

- Filing A Fee Petition

  Your representative may ask for approval of a fee by giving us a fee petition when his or her work on your claim(s) is complete. This written request describes in detail the amount of time he or she spent on each service provided you. The request also gives the amount of the fee the representative wants to charge for these services. Your representative must give you a copy of the fee petition and each attachment. If you disagree with the information shown in the fee petition, contact your Social Security office. Please do this within 20 days of receiving your copy of the petition.

  We will review the petition and consider the reasonable value of the services provided. Then we will tell you in writing the amount of the fee we approve.

What Your Representative(s) May Charge, continued

- Filing A Fee Agreement

  If you and your representative have a written fee agreement, one of you must give it to us before we decide your claim(s). We usually will approve the agreement if you both signed it; the fee you agreed on is no more than 25 percent of past-due benefits, or $6,000 (or a higher amount we set and announced in the Federal Register), whichever is less; we approve your claim(s); and your claim results in past-due benefits. We will tell you in writing the amount of the fee your representative can charge based on the agreement.

  If we do not approve the fee agreement, we will tell you and your representative in writing. Then your representative must file a fee petition to charge and collect a fee.

After we tell you the amount of the fee your representative can charge, you or your representative can ask us to look at it again if either or both of you disagree with the amount. (If we approved a fee agreement, the person who decided your claim(s) also may ask us to lower the amount.) Someone who did not decide the amount of the fee the first time will review and finally decide the amount of the fee.

How Much You Pay

You never owe more than the fee we approve, except for:

- any fee a Federal court allows for your representative's services before it; and
- out-of-pocket expenses your representative incurs or expects to incur, for example, the cost of getting your doctor's or hospital's records. Our approval is not needed for such expenses.

Your representative may accept money in advance as long as he or she holds it in a trust or escrow account. We usually withhold 25 percent of your past-due benefits to pay toward the fee for you if :

- your retirement, survivors, disabilty insurance, and/or supplemental security income claim(s) results in past-due benefits;
- your representative is an attorney or a non-attorney participating in the direct fee payment project; and
- your representative registers with us for direct payment before we effectuate a favorable decision on your claim.

You must pay your representative directly:

- the rest of the fee you owe
  if the amount of the fee is more than any amount(s) your representative held for you in a trust or escrow account and we withheld and paid your representative for you.
- all of the fee you owe
  if we did not withhold past-due benefits, for example, because your representative waived direct payment, or you discharged the representative, or the representative withdrew from representing you before we issued a favorable decision; or if we withheld, but later paid you the money because your representative did not either ask for our approval until after 60 days of the date of your notice of award or tell us on time that he or she planned to ask for a fee.

DDL

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last)*

SSN _ _

Birthday *(mm/dd/yy)*

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records;*** **also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s)** ***including*****, and not limited to:**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ▶

IF not signed by subject of disclosure, specify basis for authority to sign

☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed

Street Address

Phone Number (with area code)

City

State

ZIP _

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶

IF needed, second witness sign here (e.g., if signed with "X" above)

SIGN ▶

Phone Number (or Address)

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827,
"Authorization to Disclose Information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by SSA is protected by the Privacy Act of 1974. Once medical information is disclosed to SSA, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). SSA retains personal information in strict adherence to the retention schedules established and maintained in conjunction with the National Archives and Records Administration. At the end of a record's useful life cycle, it is destroyed in accordance with the privacy provisions, as specified in 36 CFR part 1228.

SSA is authorized to collect the information on form SSA-827 by sections 205(a), 223(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(1) and 1631 (e)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility, or continuing eligibility, for benefits, and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in SSA. In some cases, your information may also be reviewed by SSA personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by SSA without your consent if authorized by Federal laws such as the Privacy Act and the Social Security Act. For example, SSA may disclose information:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist SSA to establish rights to Social Security benefits and/or coverage;
2. Pursuant to law authorizing the release of information from Social Security records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs(VA));
3. For statistical research and audit activities necessary to ensure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract with SSA).

SSA will not redisclose without proper prior written consent information: (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from any Social Security Office.

PAPERWORK REDUCTION ACT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING IN THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send **only** comments relating to our time estimate to this address, not the completed form.

DDL

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name _____ *Date of Birth _____ *Social Security Number _____

I authorize the Social Security Administration to release information or records about me to:

*NAME	*ADDRESS
GENEX Services, Inc.	440 E. Swedesford Rd. Suite 1000 Wayne, PA. 19087

*I want this information released because:
There may be a charge for releasing information.
I am pursuing Social Security Disability benefits and the information is needed to assist with my representation.

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☑ Current monthly Social Security benefit amount
- ☑ Current monthly Supplemental Security Income payment amount
- ☐ My benefit/payment amounts from _____ to _____
- ☐ My Medicare entitlement from _____ to _____
- ☐ Medical records from my claims folder(s) from _____ to _____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- ☑ Complete medical records from my claims folder(s)
- ☑ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) My entire record related to my claim for Social Security disability benefits.

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) 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. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(if not the individual)*: _____ *Daytime Phone: _____

Form **SSA-3288** (07-2010) EF (07-2010)

DDL

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name _____ *Date of Birth _____ *Social Security Number _____

I authorize the Social Security Administration to release information or records about me to:

*NAME	*ADDRESS
Unum - The Benefits Center	PO Box 100158 Columbia, SC 29202-3158, fax # 1-800-447-2498

*I want this information released because:
There may be a charge for releasing information.
I am pursuing Social Security Disability benefits and the information is needed to assist with my representation.

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☑ Current monthly Social Security benefit amount
- ☑ Current monthly Supplemental Security Income payment amount
- ☐ My benefit/payment amounts from _____ to _____
- ☐ My Medicare entitlement from _____ to _____
- ☐ Medical records from my claims folder(s) from _____ to _____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- ☑ Complete medical records from my claims folder(s)
- ☑ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) My entire record related to my claim for Social Security disability benefits.

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) 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. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(if not the individual)*: _____ *Daytime Phone: _____

Form **SSA-3288** (07-2010) EF (07-2010)

Social Security Disability Advocates
www.genexservices.com
disabilityadvocates@genexservices.com

Authorization to Disclose Medical Information

(Provider Name): _____

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service that has information about my health to disclose any and all of this information to my representative(s) at GENEX Services, Inc., Social Security Disability Advocates ("GENEX"). Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand any information GENEX obtains pursuant to this authorization will be used to represent me in my claim for Social Security disability benefits. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent GENEX has relied on the authorization prior to notice of revocation. I understand if I revoke, alter, or do not sign this authorization, GENEX may not be able to provide me with representation. I may revoke this authorization by sending written notice to the address above.

_____ _____

(Signature of Claimant/Patient) (Date Signed)

_____ _____

(Name – Please Print) (Social Security Number)

I, _____, signed on behalf of the claimant/patient as _____(indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

DDL

Social Security Disability Advocates
www.genexservices.com
disabilityadvocates@genexservices.com

Authorization to Disclose Psychotherapy Notes

(Provider Name): _____

I authorize any health care provider to disclose Psychotherapy Notes to my representative(s) at GENEX Services, Inc., Social Security Disability Advocates ("GENEX").

Psychotherapy Notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy Notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

I understand any information GENEX obtains pursuant to this authorization will be used to represent me in my claim for Social Security disability benefits. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent GENEX has relied on the authorization prior to notice of revocation. I understand if I revoke, alter, or do not sign this authorization, GENEX may not be able to provide me with representation. I may revoke this authorization by sending written notice to the address above.

_____ _____

(Signature of Claimant/Patient) (Date Signed)

_____ _____

(Name – Please Print) (Social Security Number)

I, _____, signed on behalf of the claimant/patient as _____(indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

DDL

Social Security Disability Advocates
www.genexservices.com
disabilityadvocates@genexservices.com

Authorization to Release Information to Disability Insurance Carrier

I authorize GENEX Services, Inc., and/or my GENEX representative, successors or assigns ("GENEX"), to release all Social Security Disability Insurance ("SSDI") application, award, appeal, and claim information to my long term disability insurer.

This information may include, without limitation, SSDI decisions, Administrative Law Judge decisions, determinations, appeals, awards, medical records, and mental health records obtained in the course of GENEX's representation of me for SSDI purposes. Subject to applicable law, certain of such information may be re-disclosed and may no longer be protected by federal privacy regulations. GENEX shall not be required to provide any information pursuant to this authorization if, in the reasonable opinion of GENEX, doing so would be contrary to any law, regulation, or court order. Any provision herein in conflict with the law of the state in which you reside is amended to conform to the minimum requirements of such laws. This authorization remains in effect during the course of my Representation by GENEX unless revoked in writing by writing to the address above. Revoking this authorization will not affect any action taken prior to receipt of your written revocation.

I agree that GENEX, its officers, directors, employees and contractors shall have no liability to me arising from or out of GENEX's compliance with this authorization, or arising from or out of its non-compliance on the basis that compliance with the authorization would be contrary to law, regulation, or court order, and waive any claim against GENEX related to such compliance or non-compliance with this authorization.

Claimant Signature: _____

Name (print): _____

Date: _____

Social Security #: _____

GENEX Social Security Disability Advocates
440 E. Swedesford Rd., Suite 1000
Wayne, PA 19087

GENEX Services, Inc.
Social Security Disability Advocates
440 East Swedesford Road
Suite 1000
Wayne, PA, 19087