Social Security Administration

Form Approved
OMB No. 0960-0566

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*signifies a required field).*

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

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

***NAME OF PERSON OR ORGANIZATION:** ExamWorks Clinical Solutions

Phone# 866-270-2516

***ADDRESS OF PERSON OR ORGANIZATION:** 2397 Huntcrest Way, Suite 200
Lawrenceville, GA 30043
Fax# 770-407-8277

***I want this information released because:** I have a reported insurance related injury case.
We may charge a fee to release information for non-program purposes.
ExamWorks Clinical Solutions has been retained to determine if Medicare's past and/or future interests should be considered.

***Please release the following information selected from the list below:**
You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☐ Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date ________ to date ________
5. ☐ My Medicare entitlement from date ________ to date ________
6. ☐ Medical records from my claims folder(s) from date ________ to date ________
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☒ Other record(s) from my file **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)** Completion of the attached form or a printout of Benefits Verification letter that includes Medicare part A, B & D; SSDI benefit status; dates when benefits began or ended; SSDI application/denial/appeal status & dates; # of quarters worked.

I am the individual, to whom the requested information or 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 (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and 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 seeks or obtain access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** ***Date:** 2-27-18

***Address:** ________

Relationship (if not the subject of the record): ________ ***Daytime Phone:** ________

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)