CONSENT TO RELEASE OF MEDICAL AND OTHER RECORDS AND INFORMATION

CLAIMANT NAME: _____

SOCIAL SECURITY #: _____

TO: _____

I hereby authorize and request the above-named source to disclose any and all records concerning me including, but not limited to, medical records, employment records, and government records and to provide any information requested concerning me to Advocacy and / or the agents and employees of Advocacy.

I specifically authorize my hearing representative to receive any records or information concerning any condition of psychological or psychiatric illness, drug abuse, alcoholism, sickle cell disease, HIV positively, or AIDS which I may suffer. My hearing representative may use these records for any purpose except as restricted by the provider of records or information. I understand that these records are being requested to help in my Social Security disability claim.

I hereby acknowledge that the doctrine of informed consent has been explained to me and that I understand the contents to be released, the need for the information, and that there are statues and regulations protecting the confidentiality of authorized information. I hereby acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken. Unless and until revoked by me by notice to my hearing representative and the above-named provider of records or information this consent shall be valid for four years from the date of my signature.

_____ _____

DATE CLIENT