

Social Security Administration
Consent for Release of InformationTo: **Social Security Administration**

Name _____ Date of Birth: _____ SS# _____

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

NAME

ADDRESS

Physicians Medical Review
(561) 998-76007601 North Federal Highway, Suite 230-A
Boca Raton Florida, 33487

I want this information released because:

To establish my Social Security Disability status, date of entitlement to Medicare, and the basis for Medicare entitlement (disability or age) for the purpose of my Workers' Compensation or Liability claim. (There may be a charge for releasing information*)

Please release the following information:

- Social Security Number
- Identifying information (including date and place of birth, parents' names)
- Monthly Social Security benefit amount
- Monthly Supplemental Security Income payment amount
- Information about benefits/payments I received from _____ to _____
- Information about my Medicare claim/coverage from _____ to _____
- Medical Records
- Record(s) for my file (specify) _____
- Other (specify) - Medicare Health Insurance Claim # (HICN #), SSDI entitlement date, Medicare Part A,B & D entitlement dates date applied for disability benefits; date SSDI payment started, current SSDI payment status, and current SSDI payment amount.

Information about benefits/payments I received from

This information may be faxed to Physicians Medical Review, Fax: (561) 998-0488

*Physicians Medical Review, will be responsible for any charges that may apply for the release of information

I am the individual (or that person's parent-if a minor) or legal guardian to whom this information/ record applies. I declare, under penalty of perjury, that I have examined all the information on this form and that it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, both commits a crime and may be sent to prison, or may face other penalties.

Signature: _____

(Show signatures, names, and addresses of two people if signed by mark.)

Date _____ Relationship: _____