

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

(Name) 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:

\*ADDRESS OF PERSON OR ORGANIZATION::

Law Office of Beverly Manley & Associates, P.C.

P.O. Box 450534 Atlanta, GA 31145-0534

\*I want this information released because: There is a need to establish the date of my SSDI entitlement, my Medicare We may charge a fee to release information for non-program purposes.

status, date of entitlement for Medicare, and basis for entitlement (disability or age). Is there a representative payee designated to receive benefits on my behalf? If so, provide representative payee name.

\*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
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)

Social Security entitlement status, date of entitlement or date of application if still pending, basis for entitlement, Medicare status, date of entitlement for Medicare. If not a current Social Security recipient, include number of quarters paid in.

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:

\*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.

Table with 2 columns: 1. Signature of witness, 2. Signature of witness; Address(Number and street, City, State, and Zip Code)