Social Security Administration

Form Approved

Consent for Release of Information

OMB No. 0960-0566

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:	*ADDRESS OF PERSON OR ORGANIZATION:
GENEX Services, LLC MSA Department	440 E. Swedesford Road Suite 1000 Wayne, PA 19087

***I want this information released because:**

We may charge a fee to release information for non-program purposes.

It has been requested that I establish my Social Security Disability and Medicare entitlement status for the purpose of a workers' compensation or liability claim.

***Please release the following information:**

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.

___ Social Security Number
___ Current monthly Social Security benefit amount
___ Current monthly Supplemental Social Security Income payment amount
___ My benefits or payment amounts from _____ to _____
___ My Medicare entitlement from date _____ to date _____
___ 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.
___ Complete medical records from my claims folder(s)
___ Other record(s) from my file (**you must specify the records you are requesting, e.g. doctor report, application, determination or questionnaire)**
___ **SSDI insurance status, date of SSDI entitlement, if not entitled please indicate if individual has required quarters of coverage and/or date last insured, date of SSDI application, denial or appeal if still pending, Medicare Health Insurance Claim # (HICN), Medicare status, date of Medicare entitlement for parts A & B, SSI status and date of SSI entitlement** .

I am the individual to whom the 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 punishably by a fine of up to $5,000. I also understand that I must pay all applicable fees 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.

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)