FILE #

Social Security Counseling Center Authorization to Release Information Form

Patient Name: ______________________ Date of Birth: ______________
Social Security #: ______________________ Maiden/Other Name: ______________

I Authorize ____
to release information contained in my medical and/or mental health records.

Release To: Social Security Counseling Center, a Service of THE WEISBERG LAW GROUP, PLLC
3000 Town Center, Suite 1820, Southfield, MI 48075 **Telephone:** 248-281-4247 **Fax:** 248-281-7267

Purpose for Disclosure: Evidence in support of disability claim, required for the Administrative Law Judge to make an informed decision.

Date Range Requested: ____

Emergency Room

- ☐ ER Report Only
- ☐ ER Treatment Note Only
- ☐ ER Physician Record Only
- ☐ ER Discharge Summaries Only
- ☐ ER Physician/Clinical Reports Only

Inpatient Records

- ☐ IP Discharge Summaries Only
- ☐ Operative Reports and Procedure Reports
- ☐ Inpatient Abstract

Hospital Outpatient Records

- ☐ Office Visits, Progress Notes, and Consultations
- ☐ Operative Reports and Procedure Reports
- ☐ Physical/Occupational Therapy

Testing

- ☐ Diagnostic Testing Results with Labs
- ☐ Diagnostic Testing Results WITHOUT Labs

Behavioral Health/Mental Health

- ☐ **Outpatient**, Progress and Treatment Notes, and **Psychotherapy** Notes. Med Reviews, Clinic Notes, Psychiatric/Psychological Evaluations and Assessment
- ☐ **Inpatient** Discharge Summary , **Psychotherapy** Notes, Psychiatric/Psychological Evaluations and Assessments Only

Doctor's Office, Urgent Care, Clinics

- ☐ Office Visits/Progress Notes
- ☐ Consultations and Testing results
- ☐ Physical/Occupational Therapy

Miscellaneous

- ☐ Completion of enclosed form(s), signed and dated
- ☐ Vocational Records
- ☐ School Records
- ☐ Special Education Records
- ☐ SDA Decisions, Forms and Evaluations signed by a doctor.
- ☐ Other requests as described here: ______________

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I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. I understand, the persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no longer be protected by law.
c. This Authorization will expire 60 days from the date of the signature.
d. I understand this will not condition benefits payments, enrollment, *or* eligibility for benefits on the execution *of this form*.
e. I authorize the release of my information about HIV infection or AIDS, (protected under MCL 333.5131), Information about communicable diseases and serious communicable diseases and infections, as defined by statute and Michigan Department of Consumer & Industry Services (MDCIS), which included Hepatitis B, sexually transmitted diseases, venereal disease "VD", Tuberculosis "TB", human immunodeficiency syndrome, HIV infection or "AIDS" and AIDS related complex, ARC. Information about genetic testing, and information about social work or mental health services.
f. I authorize the release of my information about alcohol, drug and substance abuse treatment and information about mental health services (protected by Title 42 of the CFR, Part 2 and Title 45 of the CFR, Health Insurance Portability and Accountability Act of 1996) and can not be disclosed without my written permission unless otherwise provided for in the regulations.

______________________________ ______________________________
Signature of Patient/Parent/Personal Representative Date
(See 45CFR § 164.508(c)(1)(vi))

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Printed Name and Relationship to Patient, Parent/Personal Representative

______________________________ ______________________________
Witness Date