**Authorization to Release Information**

1. I authorize Disability Evaluation Services (DES) to use or disclose the information contained in the DES records of the individual listed below. I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. If the form is not complete, your permission will not be valid and DES will not be able to share your information with the person or organization you list on this form.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(street) (city) (state) (Zip)

Last 4 digits of SSN: \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ DES Case Number (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. DES is authorized to release the following information:

( ) Most recent DES Medical Consultative Exam Report ( ) Most recent DES Psychological Consultative Exam

( ) Complete file from most recent Application ( ) Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. DES is authorized to release the information to:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(street) (city) (state) (Zip)

4. I understand that the records may include mental health; HIV/AIDS; alcohol / drug abuse; and genetic records.

|  |
| --- |
| (optional) I do NOT allow the release of records that contain:  [ ] Mental Health records [ ] HIV/AIDS records; [ ] Alcohol/drug abuse treatment records; [ ] Genetic records |

5. I authorize the release of this information for the following purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. This authorization expires 6 months from signature date.

* I understand that I have the right to revoke this authorization in writing at any time, unless it has already been acted upon. To revoke this authorization, I need to send my request in writing to Disability Evaluation Services, 333 South Street, Shrewsbury, MA 01545 and include name, address, and phone number in the request.
* I understand that if I choose not to give or if I choose to cancel this permission I will still be eligible for benefits that I am entitled to.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Individual Signature of Individual Date (MM/DD/YEAR)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Signature of Individual’s Personal Representative Relationship to Individual