i3368 screenshots

Medical Release Page





To holp us make a decision about your disability claim, we need to have medical information that shows you have a disability. The law requires us to have your signed Medical Release Form (Authorization to Disclose Information to the Social Security Administration) in order to get your medical records from your disclose, hospitals and other sources. We may not be able to approve your disability claim without this signed authorization.

You must review the entire <u>Medical Release Form</u> before agreeing to sign. The form contains information about how it will be used and explains the possible consequences of not signing the form.

I voluntarily authorize and request disclosure of all my medical records; also education records and other information related to my ability to perform tasks.

- I have read and agree to sign the Medical Release Form
- © LDO NOT agree to sign the Medical Release Form



Your authorization will not be effective until you trush and submit the entire Adult Disability Report. Your name and the date will display in the form's signature box. This electronic signature is a substitute for your handwritten signature. You can print a copy of the signed and dated form upon submission.

No Path



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|Njext >>

Medical Release Form

To help us make a decision about your disability claim, we need to have medical information that shows you have a disability. The law requires us to have your signed Medical Release Form (Authorization to Disclose Information to the Social Security Administration) in order to get your medical records from your dectors, hospitals and other sources. We may not be able to approve your disability claim without this signed authorization.

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- ©I have read and agree to sign the Medical Release Form
- #I DO NOT agree to sign the Medical Release Form



If you do not agree to sign this form, the processing of your disability claim may be delayed. We may not be able to approve your claim without your signed authorization.

|Sjign Off (Knish later) | experience | Njextee

Medical Release Form in popup window



Adult Disability Report



AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

** PLEASE READ THE ENTIRE FORM BEFORE SIGNING **

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange): OF WHAT All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

- 1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
- Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
- Drug abuse, alcoholism, or other substance abuse
- Sickle cell anemia
- Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records
 of HIV/AIDS
- · Gene-related impairments (including genetic test results)
- 2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
- 3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
- 4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- · All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- · Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

TO WHOM

The Social Security Administration and to the State agency authorized to process my case (usually called "disability determination services"), including contract copy services, and doctors or other professionals consulted during the process. [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE

Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

EXPIRES WHEN

This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read the entire form and agree to the disclosures above from the types of sources listed.

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827, "Authorization to Disclose Information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by SSA is protected by the Privacy Act of 1974. Once medical information is disclosed to SSA, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). SSA retains personal information in strict adherence to the retention schedules established and maintained in conjunction with the National Archives and Records Administration. At the end of a record's useful life cycle, it is destroyed in accordance with the privacy provisions, as specified in 36 CFR part 1228.

SSA is authorized to collect the information on form SSA-827 by sections 205(a), 223(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(1) and 1631 (e)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility, or continuing eligibility, for benefits, and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in SSA. In some cases, your information may also be reviewed by SSA personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by SSA without your consent if authorized by Federal laws such as the Privacy Act and the Social Security Act. For example, SSA may disclose information:

- 1. To enable a third party (e.g., consulting physicians) or other government agency to assist SSA to establish rights to Social Security benefits and/or coverage;
- 2. Pursuant to law authorizing the release of information from Social Security records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs(VA));
- 3. For statistical research and audit activities necessary to ensure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract with SSA).

SSA will not redisclose without proper prior written consent information: (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from any Social Security Office.

PAPERWORK REDUCTION ACT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING IN THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

Form \$\$A-827 (4-2009) ef (04-2009) Use 2-2003 and Later Editions Until Supply is Exhausted



Review

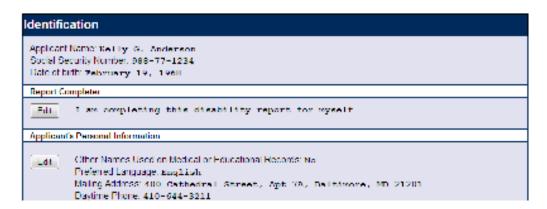
This is an opportunity to review the answers you have provided thus far. You will be given an opportunity to print your information after you submit your report.

It any sections are not complete, please see if you have the information to complete them. It not, go ahead and send the report in as it is and we'll help you with the rest.

Note: You will have to complete information for the fields marked with @

Skip down to:

- Identification
- Medical
- Work/Education
- Remarks



Alternate Phone: 443-799-6692

Reentry Number

Reentry Number#: D94217143

Other Contact



Name: Chris Anderson Relationship: Husband or Wife Mailing Address: 400 Cathedral Street, Apt 7A, Baltimore, MD 21201 Daytime Phone: 866-867-5309 Preferred Language: English

Back to Top

Medical

Conditions



List of physical and mental conditions:

1: type 2 diabetes

2 heart disease

3: COPD

Height without shoes: 5 feet, 8 inches

Weight without shoes: 260 pounds

Conditions cause pain or other symptoms: Yes

Seen a healthcare provider or received treatment, or have an appointment scheduled:

For physical conditions: Yes
For mental conditions: Yes

Doctors and Other Healthcare Professionals



Doctor/Professional #1: Dr. Samantha Gupta

Office Name: Physicians Associate Group

Address: 900 Caton Avenue, Suite 301, Catonsville, MD 21229

Phone: 410-496-9643

Reason for visits: diabetes, heart disease, COPD

Treatments received: blood pressure and breathing monitored

First visit: 2001 Last visit: 03/2011

Next scheduled appointment: None



Doctor/Professional #2: Dr. Elijah Saunders

Address: 2200 Kernan Drive, Room 4611, Baltimore, MD 21207

Phone: 410-328-4266

Reason for visits: depression, pain management Treatments received: therapy First visit: 11/2008 Last visit: 06/2011 Next scheduled appointment: 08/2011 Add Doctor/Healthcare Professional Hospitals and Clinics



Hospital/Clinic #1: Union Memorial Hospital

Address: 201 East University Parkway, Suite 226, Baltimore, MD 21218

Phone: 410-554-2532

Inpatient Stays: Date In: 03/2011 Date Out: 03/2011

Outpatient Visits: None

Emergency Room Visits: First visit: 2009 Last Visit: 2011

Reason for visits: heart surgery, couldn't breathe well

Treatments received: surgery



Hospital/Clinic #2: Vancouver General Hospital

Address: 855 West 12th Avenue, Vancouver, Canada V5Z 1M9

Phone: 604-875-4111 Inpatient Stays: None Outpatient Visits: None

Emergency Room Visits: 10/2010

Reason for visits: thought I was having a heart attack

Treatments received: observation

Add Hospital/Clinic

Tests



Test #1: EKG

Sent for test by: Doctor at Vancouver General Hospital

Date of test: 10/2010

Edit

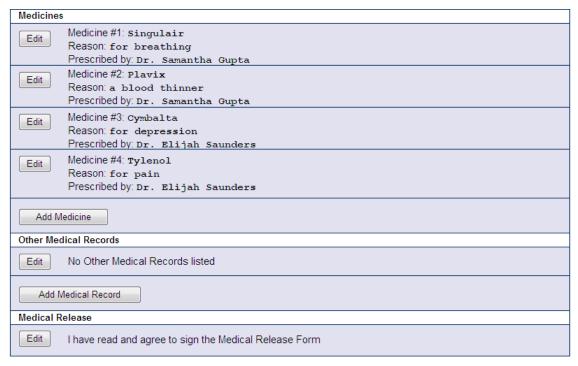
Test #2: x-Ray

Test Description: chest

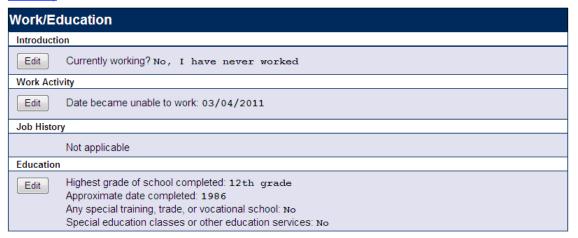
Sent for test by: Doctor at Vancouver General Hospital

Date of test: 10/2010

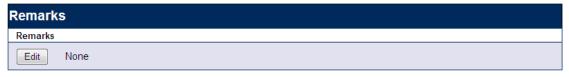
Add Test



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Back to Top



Back to Top

[S]ign Off (finish later) << [P]revious [N]ext >>

[S]ign Off (finish later)



Pjevious

Submit



|Njext >>

Receipt for Your Records

Thank you for completing this disability report. This is your recount

Print or save this page for your records. If you choose to save this page, save it as a file and not as a bookmark. Note hite

Print this page

Your Online Adult Disability Report and esigned and dated Medical Release Form were received on June 6, 2011 at hh:mm:ss Eastern Time. We will process them at your local Social Security Office.

What to Expect

- It takes about 120 days to make a disability decision. Every case is different. We may take more or less time on your case.
- We may contact you for more information while we work on your case.
- If we need more medical evidence, we may ask you to see a doctor for a special examinee of charge.

Contact us immediately if you:

- A change of address or phone number
- Visit to a new doctor
- A new medical test.
- A change in medical condition
- A change in work activity.

To Contact Social Security:

- Call our foll-tree number, 1-800-772-1213. It you are deat or hard of bearing, call our foll tree "TTY" number, 1-800-326-0778.
 Representatives are available Monday through Enday from 7 a.m. to 7 p.m., or
- Contact your local Social Security office at the address below

SOCIAL SECURITY ADMINISTRATION 1010 Park Ave Suite 200 Baltimore, MD 21201 (866) 931-9942

Identification

Applicant Name: Kelly G. Anderson Social Security Number: 988-77-1234 Date of birth: February 19, 1968

Report Completer

I am completing this disability report for myself

Applicant's Personal Information

Other Names Used on Medical or Educational Records: No

Preferred Language: English

Mailing Address: 400 Cathedral Street, Apt 7A, Baltimore, MD 21201

Daytime Phone: 410-644-3211 Alternate Phone: 443-799-6692

Other Contact

Name: Chris Anderson Relationship: Husband or Wife

Mailing Address: 400 Cathedral Street, Apt 7A, Baltimore, MD 21201

Daytime Phone: 866-867-5309 Preferred Language: English

Back to Top

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Conditions

List of physical and mental conditions:

- 1: type 2 diabetes
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Tests	
	Test #1: EKG
	Sent for test by: Doctor at Vancouver General Hospital
	Date of test: 10/2010
	Test #2: x-ray
	Test Description: chest
	Sent for test by: Doctor at Vancouver General Hospital
	Date of test: 10/2010
Medicines	
	Medicine #1: Singulair
	Reason: for breathing
	Prescribed by: Dr. Samantha Gupta
	Medicine #2: Plavix
	Reason: a blood thinner
	Prescribed by: Dr. Samantha Gupta
	Medicine #3: Cymbalta
	Reason: for depression
	Prescribed by: Dr. Elijah Saunders
	Medicine #4: Tylenol
	Reason: for pain
	Prescribed by: Dr. Elijah Saunders
Other Med	ical Records
	No Other Medical Records listed
Medical Re	lease
- 	I have read and agree to sign the Medical Release Form

Back to Top

Vork/Education
Introduction
Currently working? No, I have never worked
Work Activity
Date became unable to work: 03/04/2011
Job History
Not applicable

Education

Highest grade of school completed: 12th grade Approximate date completed: 1986 Any special training, trade, or vocational school: No Special education classes or other education services: No

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Remarks
Remarks
None

Back to Top

Medical Release Medical Release Form Form Approved OMB No. 0960-0623 WHOSE Records to be Disclosed NAME (First, Middle, Last) Kelly G Anderson

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)
** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW

SSN

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange): All my medical records; also education records and other information related to my ability to OF WHAT

perform tasks. This includes specific permission to release:
1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s).

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 Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
 Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

 All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

988-77-1234 (mm/dd/yy)

02/19/68

	nal sources (schools, teachers	.						
	inistrators, counselors, etc.)							
	xaminers used by SSA							
	nsurance companies, workers							
compensation programs Others who may know about my condition (family, neighbors, friends, public officials)								
								TO WHOM
TO WITOM	determination services"), in							
	process. [Also, for international claims, to the U.S. Department of State Foreign Service Post.]							
PURPOSE	Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.							
	Determining whether I			• •	-			
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	to SSA and my sources to rev					s (see page 2 for det	anoj.	
 SSA will give 	e me a copy of this form if I as	k; I may ask	the source to all	ow me to inspect or ge	t a copy of ma			
 I have read 	both pages of this form and	agree to th	ne disclosures a	bove from the types	of sources list	ted.		
PLEASE SIGN	USING BLUE OR BLAC	KINK ONL	Y IF not signe	d by subject of dis				
NDIVIDUAL	authorizing disclosure		☐ Parent o	of minor 🔲 Guardia		r personal represe	entative	
SIGN > F	Kelly G Anderson				(exp	iain)		
	terry o Anderson		here if two signa	n/personal representative atures required by State la				
Date Signed 06/06/2	2011 10:27 am	Street Add	ress 400 (Cathedral St	reet, A	•		
Phone Number ((410) - 64	(with area code) 4-3211	City	Baltimor	e		State Z MD	21201	
WITNESS	I know the person sign	ing this for	m or am satisfie	ed of this person's id	entity:			
SIGN >	, ,			IF needed, second w	itness sign her	e (e.g., if signed with	"X" above)	
Phone Number	(or Address)			Phone Number (or A	ddress)			
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	d special authorization to discl							
	n under P.L. 104-191 ("HIPAA .475; 20 U.S. Code section 12					CFR part 2; 38 U.S. (Code section	
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orm 55A-827 (4	4-2009) ef (04-2009) Use 2-20	ius and Late	er Editions Until 5	uppiy is Exnausted			rage 1012	
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			•	orm SSA-827,				
	"Authorization to I	nsclose In	formation to t	he Social Security	Administrat	ion (SSA)"		
We need your	written authorization to he	p get the i	nformation req	nired to process you	r claim, and	to determine your	capability	
	enefits. Laws and regulatio							
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ducational sor								
Von can provid	le this authorization by sig	ning a form	n SSA-827. Fe	deral law permits so	urces with in	formation about v	ou to	

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- To enable a third party (e.g., consulting physicians) or other government agency to assist SSA to establish rights to Social Security benefits and/or coverage;
- Social Security benefits and/or coverage,

 2. Pursuant to law authorizing the release of information from Social Security records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs(VA));
- For statistical research and audit activities necessary to ensure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract with SSA).

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Form SSA-827 (4-2009) ef (04-2009)

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Next Steps not from iClaim



Next Steps



You have completed two of the three steps in the Disability Application Process.

You will need to:

Complete the Disability Application (about 15 minutes) by selecting the Go to Application button at the bottom of this
page, OR file the application online later by going to www.socialsecuity.gow/disabilityonline/ and selecting "Apoly for Benefits."

Send Medical Records if readily available. You can help us make a faster decision on your application by providing us with any medical records you have. Please mail or bring them into your local Social Security office with the Cover Sheet.

Please visit our Erequently Asked Questions (EAQ) page it you need more information about our disability programs.

To contact Social Security

- Call our tell-tree number, 1-800-772-1213. It you are deat or hard of bearing call our tell-tree "TTY" number, 1-800-325-0778.
 Representatives are available Monday through Enday from 7 a.m. to 7 p.m.
- Contact your local Social Security office at the address below.

SOCIAL SECURITY ADMINISTRATION 1010 Park /we Surte 200 Battimore, MD 21201 (800) 931-4842

Return to Receipt

Go to Application



Additional Information



You have completed the three steps in the Disability Application Process.

You can also:

Send Medical Records if readily available. You can help us make a taster decision on your application by providing us with any medical records you have. Please mail or bring them into your local Social Security office with the Cover Sheet.

Please visit our Enguently Asked Questions (EAQ) page it you need more information about our disability programs.

to leave this page, select the Finished button at the bottom of this page.

To contact Social Security.

- Call our toll free number, 1-800-772-1213. If you are deaf or hard of hearing call our toll free "TTY" number, 1-800-325-0778.
 Representatives are available Monday through Friday from 7 a.m. to 7 p.m.
- Contact your local Social Security office at the address below

SOCIAL SECURITY ADMINISTRATION 1010 Park Ave Surte 200 Datimore, MD 21201 (800) 931-8842

Return to Receipt

Finished

Overview not from iClaim



Overview from iClaim



This Disability Report is one step in the disability claim process described below. You have already completed the Disability Application

Steps in the Disability Claim Process:

- Disability Application You have sheady completed the Disability Application
- Disability Report (about 90 minutes)—you provide us with your medical and work history.
- Medical Release Form (about 5 minutes) you allow us to get information from your doctors.

Note: Print and review the Adult Disability Checklist so you know what information you need to begin the Disability Report. (The Adult Disability Checklist requires <u>Adube Resider</u> to open and print it.)

If you have not already done so, refer to <u>How to Move Around in This Report</u> to understand how to navigate and work with the Disability Report

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