AUTHORIZATION TO RELEASE RECORDS

RE: Name of Client: ______________________________
Social Security Number: ______________________________
Date of Birth: ______________________________

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of all my medical records, education records and other information related to my ability to perform tasks for the purpose of investigating and processing my claim for Social Security Disability|SSI benefits. This includes, but is not limited to 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 and past information.

FROM WHOM.

1. All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities.
2. All educational sources (schools, teachers, records administrators, counselors, etc.).
3. Social workers/rehabilitation counselors.
4. Consulting examiners used by the Social Security Administration ("SSA").
5. Employers, insurance companies, workers' compensation programs.

TO WHOM

My attorney, Craig A. Fahey ("Attorney"), his agents, employees, investigators, attorneys or representatives to whichever office my Attorney may designate in writing or fax to (888) 371-2141.

This authorization is good for 12 months from the date signed below. I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above. I understand that there are some circumstances in which this information may be redisclosed to other parties, including SSA. I may write to my Attorney and my sources to revoke this authorization at any time. My Attorney 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 this form and agree to the disclosures above from the types of sources listed.

DATED:______________ SIGNED:______________________________

This 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.