Medical Release Authorization for Disability Claim

Claimant Name:

Date of Birth:

Social Security Number:

Address:

Phone Number:

Authorization

I authorize any health care provider, hospital, clinic, insurance company, employer, or other person or organization to disclose any information regarding my health, medical history, consultations, prescriptions, or treatments (including those involving psychiatric or drug/alcohol use) to _____ for the purpose of evaluating and processing my disability claim.

Release & Acknowledgement

☐ I understand that this authorization is voluntary and that I may revoke it at any time in writing, except to the extent that action has been taken in reliance on it.

☐ This authorization will expire one year from the date signed below, unless otherwise specified.

Other Expiration Date or Event:

Signature of Claimant

Date

Signature of Personal Representative (if applicable)

Relation to Claimant