

Social Security Administration  
Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number
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I authorize the Social Security Administration to release information or records about me to:

Name	Address
Concierge Medical and Risk Consultants (336) 270-5207	332 Holly Hill Lane Burlington, NC 27215

I want this information released because:

To establish my Social Security Disability status, date of entitlement to Medicare, and the basis for Medicare entitlement (disability or age) for the purpose of my Liability claim or Worker's Compensation claim to be obtained from the Social Security Administration or the MyMedicare.gov website.

(There may be a charge for releasing information.)

Please release the following information:

- Social Security Number
- Identifying information (includes date and place of birth, parents' names)
- Monthly Social Security benefit amount
- Monthly Supplemental Security Income payment amount
- Information about benefits/payments I received from \_\_\_\_\_ to \_\_\_\_\_.
- Information about my Medicare claim/coverage from \_\_\_\_\_ to \_\_\_\_\_.  
(specify) \_\_\_\_\_
- Medical Records
- Record(s) from my file (specify) \_\_\_\_\_
- Other (specify) – Medicare Health Insurance Claim Number, SS entitlement date, date of denial, date of appeal, status of appeal, and/or basis for entitlement (disability or age), Medicare (parts A,B & D) status or entitlement dates, Date applied for Disability Benefits, Date SSDI payment began, and current SSDI payment status and amount

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation, which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: \_\_\_\_\_  
(Show signatures, names, and addresses of two people if signed by mark.)

Date: \_\_\_\_\_ Relationship: \_\_\_\_\_