

Social Security Administration
Consent for Release of Information

To: Social Security Administration

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

Name:	Address:
Gisclair Medical Services, LLC	10101 Siegen Lane Bldg. 2, Suite C Baton Rouge, LA 70810

I want this information released because:

To determine if my case meets the CMS review threshold in order to protect Medicare's interests under the Medicare Secondary Payer Statute.

(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 _____ All Dates to _____
- _____ Information about my Medicare claim/coverage from _____ All Dates to _____
(specify) _____
- _____ Medical Records
- _____ Record(s) from my file (specify)
- _____ Other (specify) **Verify date of birth, Social Security entitlement status, date of SS entitlement or date of application if still pending, date of denial, date of appeal, status of appeal, basis for entitlement (disability or age), name of representative payee if assigned, number of eligible work quarters, if quarters adequate for Social Security benefits, Medicare status, date of entitlement for Medicare A and B.**

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: _____