Authorization to Release of Information

1. Patient Information

Name (First Last) _____ (Maiden or any previous last names) _____ Last 4 of SSN xxx-xx- _____

Current Address _____City _____State_____ Zip Code_____ Date of Birth_____

2. Release (disclose) Information to: Aiello Law Group d/b/s Social Security Counseling Center Phone: 248-281-4247 Fax Number 248-281-1660

3. Purpose for Disclosure: Evidence in support of a Social Security disability claim, required for the Administrative Law judge to make and inform decision.

4. Requesting information from: I hereby authorize_____ its director or agent, to disclose information contained in the medical record and/or mental health records of the patient identified above, which includes information that may be stored in a paper and/or electronic format, as set forth below. Such notes may contain information on general medical care; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC); communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received by other health care providers. Any alcohol and substance use information disclosed to you in these records is protected by Federal confidentiality rules (42 CFR part 2). These Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.

5. Date(s) of Service _____

6. Specific information to be released **___ Medical Records or ___Psychiatric Records**

Hospital:

- ☐ Discharge Summary (ies) only (no labs)
- ☐ Operative Report(s)
- ☐ Outpatient Clinic, Office Visits, Progress Notes, and Consultations, Physical Therapy & Rehab visits (no labs)
- ☐ Labs

Behavioral Health/Mental Health

- ☐ **Outpatient**, Progress and Treatment Notes, and **Psychotherapy** Notes. Med Reviews, Psychiatric/Psychological Evaluations and Assessment
- ☐ **Inpatient** Discharge Summary, **Psychotherapy** Notes, Psychiatric/Psychological Evaluations and Assessments Only.

Doctor's Office, Urgent Care, Rehab, Clinics

- ☐ Office Visits/Progress Notes, and Testing results(no labs) (Minimal pages, Limited Medical Chart)
- ☐ Physical/Occupational Therapy visits only.

Miscellaneous

- ☐ Completion of enclosed form(s), signed and dated _____School Records and/or Special Education Records
- ☐ MRS evaluations, SDA Decisions, Forms and Evaluations signed by a doctor.
- ☐ Other _____

6. This authorization is valid within 60 days of the date signed or sooner by my choice, in which case the consent will expire on _____. Such expiration date or event has not occurred.

7. I may revoke or withdraw this authorization, except to the extent that action has been taken prior to the receipt of the revocation or withdrawal. Revocations to this authorization must be presented in writing to The Weisberg Law Group, PLLC Attn: Medical Records, 3000 Town Center Suite 1820 Southfield Michigan 48075. Revocation will not apply to the information that has already been released pursuant to this authorization.

8. The persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no longer be protected by law. Health Information sent in an unencrypted email or on unencrypted media (DVD/Flash drive) is not secure. The Health Information may be intercepted and seen by others. There are other risks with unencrypted email including misaddressed or misdirected messages, email accounts that are shared, messages forwarded to others, and messages that are stored on servers that have no security. By signing this you are acknowledging and accepting these risks. Your Social Security Number, home address, insurance information, medical information, and other personal information may appear on the records being sent.

9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I may inspect or copy any information used/disclosed under this authorization.

Signature: _____ **Witness:** _____

Relationship (if other than patient): _____ Parent of Minor, Legal Guardian, Personal Representative, Person under a POA*

Date: _____ **Date:** _____

Revised 1/1/2025