Authorization to Release Medical Information for Disability Claims

I hereby authorize _____ to release any and all medical information concerning my physical or mental health to _____ for the purpose of processing my disability claim.

Patient Name: _____

Date of Birth: _____

Address: _____

The information to be released includes (check all that apply):

- ☐ Diagnosis
- ☐ Treatment Records
- ☐ Test Results
- ☐ Other: _____

This authorization is valid until: _____

Signature: _____

Date: _____