T & S Advocates

Disability Representatives

AUTOHORIZATION TO RELEASE RECORDS AND INFORMATION

I,_____,SS#_____,DOB_____

Voluntarily authorize and request disclosure (including paper, oral, and/or electronic interchange) of ALL medical, mental health, and functional records and information without restriction or limitation from:

Facility_____

Address_____

Phone_____Fax_____

Please release my **information and records** to:

T & S Advocates
P.O. Box 784
Paris, Tennessee 38242
731-336-2686, www.ssaadvocates.org

Information obtained will be evaluated, and potentially redisclosed, to demonstrate my eligibility for Social Security benefits.

This authorization is valid for twelve months or until revoked in writing. A copy or electronic copy of this authorization is as valid as the original.

I agree to assume any responsibility for any cost(s) associated with this request.

_____ _____ _____
Signature Date Phone

_____
Address