

WHOSE Records to be Disclosed

NAME (First, Middle, Last, Suffix)	
SSN	Birthday (mm/dd/yy)

AUTHORIZATION TO DISCLOSE INFORMATION TO
ARBOR E & T, LLC dba ACTION REVIEW GROUP (ARG)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):
OF WHAT All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

- All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including , and not limited to :**
 - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
 - Drug abuse, alcoholism, or other substance abuse
 - Sickle cell anemia
 - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
 - Gene-related impairments (including genetic test results)
- Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
- Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
- Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by ARG
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY ARG (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM

The State contractor authorized to process my case, including contract copy services, and doctors or other professionals consulted during the process. [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE

Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN

This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties and no longer protected.
- I may write to ARG and my sources to revoke this authorization at any time (see page 2 for details).
- ARG will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ...

IF not signed by subject of disclosure, specify basis for authority to sign

Parent of minor Guardian Other personal representative (explain)

(Parent/guardian/personal representative sign here if two signatures required by State law) ...

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP

WITNESS

I know the person signing this form or am satisfied of this person's identity:

SIGN ...

Phone Number (or Address)

IF needed, second witness sign here (e.g., if signed with "X" above)

SIGN ...

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of this form
"Authorization to Disclose Information to ARBOR E & T, LLC dba ACTION REVIEW GROUP (ARG)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing this form. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to Arbor E & T, LLC dba Action Review Group (ARG). If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; Arbor E & T, LLC dba Action Review Group (ARG) can tell you if we identified any sources you didn't tell us about. Arbor E & T, LLC dba Action Review Group (ARG) may use information disclosed prior to revocation to decide your claim.

It is Arbor E & T, LLC dba Action Review Group (ARG)'s policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. Arbor E & T, LLC dba Action Review Group (ARG) makes every reasonable effort to ensure that the information in the Arbor E & T, LLC dba Action Review Group (ARG) is provided to you in your native or preferred language.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 233(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(l) and 1631(e)(l)(A) of the Social Security Act as amended, [42 U.S.C. 405(a), 433(d)(5)(A), 1382c(a)(3)(H)(i), 1383(d)(l) and 1383(e)(l)(A)] authorize us to collect this information. We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from our records (e.g., Social Security Audits / Reviews, Appeals)
3. To make medical determinations of disability based upon available medical records.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's current disability status with those agencies.

A complete list of routine uses of the information you give us is available by request by contacting Arbor E & T, LLC dba Action Review Group (ARG).

Arbor E & T, LLC dba Action Review Group (ARG) is a partner with and contracted by the State of Colorado's Department of Health Care Policy and Financing (HCPF) to perform medical records review services to determine the level and severity of disability according to the criteria and rules established by the Social Security Administration. Your records are available to HCPF for review and audit. The laws, rules, and regulations stated in the document also apply to HCPF.

Arbor E & T, LLC dba Action Review Group (ARG) does NOT provide nor establish eligibility for any Medicaid or Medicare benefits or programs.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO ARBOR E & T, LLC dba ACTION REVIEW GROUP (ARG), P.O. BOX 340, OLYPHANT, PA 18447. YOU MAY FAX THIS FORM TO ARG AT 1.877.672.2077. YOU MAY CALL ARG AT 1.877.265.1864. YOU MAY EMAIL ARG AT ACTIONREVIEWGROUPEMRT@ARBORET.COM**