

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. (*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).

TO: Social Security Administration

EVAN Alan Disney

*My Full Name

04/17/1978

*My Date of Birth
(MM/DD/YYYY)

517 137948

*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME OF PERSON OR ORGANIZATION:

*ADDRESS OF PERSON OR ORGANIZATION:

LAW OFFICES OF NATALIA FOLEY

8306 Wilshire blvd Ste 115 Beverly Hills CA 90211

SUBSEQUENT INJURIES BENEFIT TRUST FUND

160 PROMENADE CIRCLE, STE. 350

SACRAMENTO, CA 95834

*I want this information released because: my SIF benefits application

We may charge a fee to release information for non-program purposes.

*Please release the following information selected from the list below:

Check at least one box. We will not disclose records unless you include date ranges where applicable.

- 1. Verification of Social Security Number
- 2. Current monthly Social Security benefit amount
- 3. Current monthly Supplemental Security Income payment amount
- 4. My benefit or payment amounts from date 01/01/2018 to date present
- 5. My Medicare entitlement from date 01/01/2018 to date present
- 6. Medical records from my claims folder(s) from date 01/01/2018 to date present
If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
- 7. Complete medical records from my claims folder(s)
- 8. Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to \$5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

*Signature:

*Date: 8/28/2019

**Address: 120 S GRAND APT 5 ANAHEIM CA 92804

**Daytime Phone:

Relationship (if not the subject of the record):

**Daytime Phone:

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of witness

2. Signature of witness

Address(Number and street, City, State, and Zip Code)

Address(Number and street, City, State, and Zip Code)