Claimant's Social Security Number ☐☐☐-☐☐-☐☐☐☐

Appointed Representative's Rep ID ☐☐☐☐☐☐☐☐☐☐

Section 6 - Claim Type *(Claimant or Representative)*

I appoint the individual named in Section 4 to act as my representative in connection with my claim(s) or asserted right(s) under Title 2 (RSDI), Title 16 (SSI), Title 18 (Medicare Coverage), and Title 8 (SVB) of the Social Security Act, as presently amended, specifically for the issues identified below: (*Check all that apply*)

☒ Claim/Appeal for Title 2 Disability Benefits

☒ Claim/Appeal for Title 16

☒ Concurrent Title 2 and Title 16

☒ Claim/Appeal for Retirement Benefits

☒ Claim/Appeal for Title 18 (Medicare), 8 (Special Veteran's Benefits)

☒ Continuing Disability Review (CDR)

☒ Post-Entitlement Issue (a new issue you raise after eligibility for other benefits)

(E.g., benefit amount, month of entitlement, representative payee, suspension, termination, overpayment)

Section 7 - Fee Arrangement *(Representative Only)*

Check one box below:

☒ **I will request a fee and direct payment of this fee**. Select this box if you are eligible for direct payment and want us to withhold a portion of the past-due benefits to pay you the fee we may authorize. *(We must authorize the fee.)*

☐ **I will request a fee but not direct payment.** Select this box if you are not eligible for direct payment from the past-due benefits, or if you do not want direct payment. You must collect any fee we may authorize on your own. *(We must authorize the fee.)*

☐ **I waive the right to receive a fee from the claimant, any auxiliary beneficiaries or any other individual.** Select this box if you certify that an entity, or a Federal, state, county, or city government agency will pay the fee and any expenses from its funds. The claimant, auxiliary beneficiaries, or other individuals must not be liable for the fee, directly or indirectly, in whole or in part, or any expenses. *(We do not need to authorize the fee if all regulatory conditions apply.)*

☐ **I waive the right to a fee.**

Section 8 - Signatures *(Claimant and Representative)*

Representative's Signature	**Date**
Claimant's Signature	**Date**

VICTORY DISABILITY
SOCIAL SECURITY DISABILITY/SSI FEE AGREEMENT

Claimant: _____ S.S.#_____ Date: _____

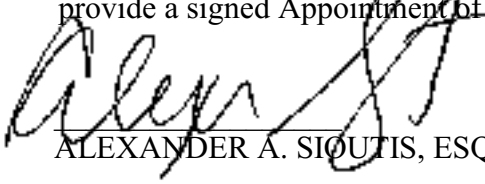
I, the Claimant, hereby appoint ALEXANDER A. SIOUTIS, ESQ of VICTORY DISABILITY LLC, to provide representation on behalf of my application for Social Security Disability and/or Supplemental Security Income Benefits.

No attorney fee will be charged unless and until the Claimant is awarded benefits. If benefits are awarded, the attorney fee will be the lesser of twenty-five percent (25%) of total past due benefits, including auxiliary (children) benefits, or the maximum set by the Commissioner of Social Security as prescribed pursuant to section 206(a)(2)(A) of the Social Security Act which is currently $6,000, but which may be increased from time to time by the Social Security Administration. If my claim is awarded with no past due benefits, I understand that my attorney may petition for fee to be approved based upon the work performed on my case. I agree to pay costs for medical records and opinions which are ordered and paid for by Victory Disability, LLC.

My representative(s) reserves the right to withdraw representation at any time for good reason, such as for lack of communication or lack of medical treatment. If I, the Claimant decide to terminate services at any time, I will be responsible for paying any outstanding expenses incurred on my behalf. I further agree that if I am awarded benefits after I have terminated services, my representative may petition for fees for services performed while appointed to my claim. Although they will use their best efforts, my representatives have not guaranteed any specific results.

ALEXANDER A. SIOUTIS, ESQ., is designated as my primary representative. I also consent to assignment of any Associates affiliated with Victory Disability LLC, to act as a main representative at the hearing. I also acknowledge and agree that some work performed will be by non-attorney personnel.

I, the Claimant, understand that my representative cannot begin representation until I provide a signed Appointment of Representation (SSA Form 1696).



_____
ALEXANDER A. SIOUTIS, ESQ.

X _____
Client Signature

_____
Co-representative

_____
Co-representative (print name)

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

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

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** 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:

1. **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)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **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.**
4. **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 SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (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 Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **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 (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA 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 ▶	**IF** needed, second witness sign here (e.g., if signed with "X" above) **SIGN ▶**
Phone Number (or Address)	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.

Claimant/Patient:_____

AUTHORIZATION

I hereby authorize use or disclosure of protected health information, employment information, or other personal information about me as described below for Social Security purposes.

1. The following specific person or class of persons or facility is authorized to make the requested use or disclosure:_____

2. The following person or class of persons may receive disclosure of protected health information about me:

Victory Disability, LLC
255 Great Valley Pkwy. Ste 150
Malvern, PA 19355
(P) 866-350-7229
(F) 866-350-7229

3. The specific information that should be disclosed is: all medical and mental health records, including sensitive information .

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I hereby discharge the releasing facility, its agents and employees, from any and all liabilities, responsibilities, damages, and claims which might arise from the release of authorization herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter, or hospitalization, or make copies thereof in accordance with the policies of this facility.

6. l may revoke this authorization by notifying the facility in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. l understand that the entity to whom this authorization is furnished may not condition its treatment of me, or payment, on whether or not I sign the authorization.

7. This authorization expires on, _____, OR one year after the date signed below, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: Social Security Determination.

8. Purpose of Disclosure: Social Security Purposes

X_____ _____
Signature of Individual or Representative Date

_____ _____
Date of Birth Social Security Number

Department of Veterans Affairs	REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS (Name and address of VA health care facility):

LAST NAME-FIRST NAME-MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Victory Disability
255 Great Valley Pkwy. Ste 150
Malvern, PA 19355

PURPOSE(S) OR NEED: Information is to be used by the organization or individual for

☐ Treatment ☐ Benefits ☐ Legal ☐ Employment ■ Other – Please specify. Social Security Disability

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

- ■ Health Summary (prior 2 years)
- ■ Inpatient Discharge Summary (dates): All medical & mental treatment records from
- ■ Progress Notes:
  - ☐ Specific clinics (name & date range):
  - ☐ Specific providers (name & date range):
  - ■ Date range: All medical & mental health records from all VA clinics/health centers from
- ■ Operative/Clinical Procedures (name &date): All operative and procedure reports form
- ☐ Lab results:
  - ☐ Specific tests (name & date):
  - ☐ Date range:
- ■ Radiology Reports (name & date): All X-rays, MRIs, CTs, ultrasounds, etc from
- ■ List of Active Medications
- ☐ Flu Vaccination (dose, lot number, date & location)
- ☐ Other (describe below):

LAST NAME-FIRST NAME-MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize the Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization:

■ Drug Abuse ■ Alcoholism or Alcohol Abuse ■ Sickle Cell Anemia
■ Human Immunodeficiency Virus (HIV)

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion, or because a condition of VA employment mandates the signing of this authorization. The information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any information disclosed per this authorization may no longer be protected by Federal confidentiality laws or regulations and may be subject to re-disclosure by the recipient.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire

☐ After one-time disclosure, if all needs are satisfied
☐ On _____ (enter a future date other than date signed by patient)
■ Under the following condition(s): **2 years from the date of patient's signature**

PATIENT SIGNATURE	DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable)	**DATE (mm/dd/yyyy)**

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

Type and Extent of Material Released:

Date Released:	Released by:

HITECH RECORDS REQUEST

Dear Records Custodian:

I am a patient of your medical practice. I request that all records provided per the accompanying medical record request form be in electronic format pursuant to 42 U.S. Code §17935 - the Health Information Technology for Economic and Clinical Health (HITECH) Act.

The HITECH act states in pertinent part:

> in the case that a covered entity uses or maintains an electronic health record with respect to protected health information of an individual –
>
> 1. The individual shall have a right to obtain from such covered entity a copy of such information in an **electronic format and, if the individual chooses, to** direct the covered entity to transmit such copy directly to an entity of person designated by the individual**,** provided that any such choice is clear, conspicuous, and specific; and
> 2. Notwithstanding paragraph (c)(4) of such section**, any fee** that the covered entity may impose for providing such individual with a copy of such information ... **shall not be greater than the entity's labor costs in responding to the request for the copy.**

In Fed. Reg. vol. 78, No.17, the Department of Health and Human Services further explained that a medical provider may charge a reasonable, cost-based fee, but only for (1) The supplies for, and labor of, copying the records; (2) the postage to mail the records, if applicable; and (3) the preparation of an explanation of summary of the records, if agreed to by the patient. Fees associated with maintaining systems and recouping capital for data access, storage and infrastructure are NOT considered reasonable, cost-based fees. **The provider may not charge a retrieval fee**. **The provider has only 30 days to produce the records from the date of receipt of the request**.

Providers that spend significant time to reach agreement on the electronic format for a response to a request are using part of the 30 days permitted for response. They must provide records within 30 days of the receipt of the request I am requesting my chart for the following dates of service: _____

Please send the electronic records directly to

Victory Disability
Fax: 866-350-7229
Email: hearings@victory-disability.com

I FURTHER AUTHORIZE YOU AND YOUR VENDOR, IF APPLICABLE, TO COMMUNICATE DIRECTLY WITH XEBEE RECORDS, LLC REGARDING ALL ISSUES RELATED TO THIS REQUEST INCLUDING AUTHORIZATION OF THE COST-BASED CHARGES AND THE TIME FRAME FOR PROVIDING THE RECORDS.

SIGNED: DOB: DATED:

HITECH Records Request

Patient Authorization to Disclose Protected Health Information

Patient Name	Date of Birth	Social Security Number

I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization named:

Release by:	Release to:
Facility name:	**Victory Disability**
Address:	**255 Great Valley Pkwy. Ste 150**
City, State, Zip Code:	**Malvern, PA 19355**

Purpose of Disclosure:	**Type of Disclosure Authorized & Delivery Instructions:**
X Legal	Provide electronic copies of records to Victory Disability via facsimile: (866) 350-7229 or via email: hearings@victory-disability.com

Pertinent Protected Health Information Allowed to be Included:

X Entire Medical Record for the following treatment dates: _____

__ Other (specify): _____

Authorization: I certify that this request is made voluntarily, and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management/Medical Records department in accordance with HIPAA regulation 42CFR Part 2. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment in health plan, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer.

Copy Fees: I request that all records provided per the accompanying medical record request form be in electronic format pursuant to 42 U.S. Code §17935 – the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless a different date is specified here: _____

Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to: diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

Signature: _____

Date: _____

Patient (Parent or Legal Guardian)

Relationship (if other than patient):_____

A copy or fax of this authorization shall be as valid as the original