Medical Information Release Authorization

The undersigned hereby grants permission to Summit Payee Services, Inc. to discuss any and all medical related information with any medical practitioner, hospital, facility, or any other agency that has medical records or knowledge of the length of hospitalization, dates of admission and release, and ongoing prognosis.

The undersigned hereby authorizes any medical practitioner, hospital, facility, or any other agency that has medical records or knowledge of the length of hospitalization, dates of admission and release, and ongoing prognosis to release such information upon request to Summit Payee Services, Inc.

The undersigned understands that:

- I may revoke this medical information release at any time, in writing, but the release shall remain valid until revoked or upon the termination of Summit Payee Services, Inc. as Representative Payee of record with the Social Security Administration.
- This release may include medical records and dates of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse.
- Summit Payee Services, Inc. will maintain the privacy of any information obtained and will not disclose such information to any other person or entity except as required by the Social Security Administration.
- A copy of this form, including a facsimile, may be used in place of the original.

I acknowledge that I have read and understand this Medical Information Release Authorization. Further, I authorize the disclosure of my protected health information in accordance with the terms in this Authorization.

____
Patient Name

____
Signature of Patient or Legal Guardian if Patient is a Minor

____
Address

____
Date

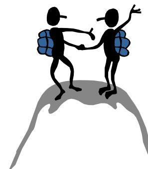
____
City, State, Zip

____
Date of Birth

____
Patient SSN

San Bernardino: 909-884-5299
Riverside: 951-263-9527
Fax: 909-885-2859

1361 North E Street
San Bernardino, CA 92405-4506



Summit Payee Services, Inc.

A California non-profit corporation