AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION TO THE MARSHALL ISLANDS SOCIAL SECURITY ADMINISTRATION

(Please read the entire form before signing below)

To:

- All medical/treating sources (hospitals, clinics, labs, physicians, psychologist, etc.) including mental health, correctional, addiction treatment and other health care facilities;
- All educational sources (schools, teachers, record administrators, counselors, etc.);
- Social workers and rehabilitation counselors;
- Consulting Medical Examiner(s) appointed by the Marshall Islands Social Security Administration;
- My present and previous Employers; and
- Others who may know about my physical and medical condition (family, neighbors, friends, public officials

I, _____, voluntarily authorize and request disclosure (including paper, oral and electronic interchange) of all my medical records to the Marshall Islands Social Security Administration (MISSA) and/or to MISSA's designated Medical Examiners, at P.O. Box 175, Majuro, Marshall Islands, MH 96960. This includes specific permission to release:

1. All records and related information regarding my treatment, hospitalization and outpatient care for my impairment(s), including, but not limited to:
   - Physical, psychological, psychiatric or other mental impairment(s)
   - Drug abuse, alcoholism and other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or sexually transmitted diseases which may include, but are not limited to, hepatitis, syphilis, gonorrhea and HIV/AIDS.
   - Gene-related impairment, including genetic test results
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living and my ability to work.
3. Copies of educational tests or evaluations, including individualized education programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observation and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

The purpose of this disclosure is to determine my eligibility to disability benefits, including looking at the effect of my impairment that by itself would or would not meet MISSA's definition of disability. This authorization is valid for 12 months from the date stated below my signature:

Individual authorizing disclosure: SIGN ➡	Name & signature of parent/guardian/representative, if subject is a minor or incapacitated:
Date:	Date:
Address:	Address:
Telephone:	Telephone: