SMITH GODIOS SORENSEN INC.
DISABILITY ATTORNEYS

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216.479.6474

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877.230.5500

SOCIAL SECURITY FEE AGREEMENT

I hereby employ SMITH GODIOS SORENSEN INC. to represent me before the Social Security Administration. If SSA favorably decides my claim(s) and the decision results in past-due (retroactive benefits), I agree to pay my representative(s) a fee that does not exceed the lesser of 25 percent of my past due benefits or the maximum dollar amount allowed under the Social Security Act Section 206(a)(2), or such higher amount set by the Commissioner of Social Security. I also understand that the approved attorney fees will be withheld and paid directly to my Attorneys. If for some reason the moneys are not withheld, I agree to pay the approved fee.

I understand that a fee is only payable if a favorable decision is made in my claim(s) and if retroactive benefits are awarded.

Whether we win or lose my claim(s), I agree to reimburse my Attorneys for all out of pocket expenses which they incur in presenting my claim(s) to the Social Security Administration. These expenses shall not exceed $100.00 unless my Attorneys advise me in writing of the excess charges.

If a representative payee is required to handle my benefits, I hereby authorize my representative payee to pay any fees due and owing under this agreement to my Attorneys.

I agree that this Agreement shall be construed according to the laws of the State of Ohio. Furthermore, regardless of where this Agreement was signed, the Agreement shall be considered signed in Akron, Ohio.

I further agree that failure to cooperate can result in my Attorneys withdrawing as representative in my claim(s). I further agree that my Attorneys may withdraw as my representative for any other legal, business, or ethical reason.

I acknowledge that I have received a signed copy of this agreement.

X X

Date

SCOTT F. SMITH

CHRISTOPHER N. GODIOS

SHANNON E. SORENSEN

KANDICE R. EVELSIZER

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 XX	**Date**

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 applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below at 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 the 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 ▶ X

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)
(330) 762-6474

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.

Form **SSA-1696-U4** (03-2011) ef (03-2011)
Destroy Prior Editions

FILE COPY

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ **Date of Birth**: _____

I authorize the use or disclosure of the above named individual's health information as described below:
The following individual or organization is authorized to make the disclosure:

Name: _____

Address: _____

The type and amount of information to be used or disclosed is as follows:

Treatment summary/office notes from _____ to _____
Emergency room records/discharge summary from _____ to _____
MRI, CT scans, blood work, ECG, NCT, etc. from _____ to _____
Psychiatric/Psychological exams/treatment notes from _____ to _____
Laboratory results from _____ to _____
Radiology results from _____ to _____
Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that my alcohol and/or drug abuse treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR, Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Ohio Law (Mental Health ORC 5122.27.09), (HIV/AIDS ORC 3701.24.3) also prohibits further redisclosure of this information without the written consent of the person to whom it pertains. This information may be disclosed only to the Social Security Administration and used by the following individual or organization:

SMITH GODIOS SORENSEN INC., Attorneys at Law
411 Wolf Ledges Pkwy., Suite 400, Akron, OH 44311
For the purpose of assisting in obtaining Social Security benefits

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: **90 days**. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

X _____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness

Cleveland Clinic

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. Patient Information:		
Name *(First, Middle, Last)*		Cleveland Clinic Medical Record #
Current Address		City Akron State OHZip 44314
Last 4 Digits of Social Security #	Email	Phone Number Date of Birth

2. Release Information From (check all that apply):	3. Release Information To:
X Cleveland Clinic Ohio facilities OR Specify Cleveland Clinic Ohio facility(ies):_____	Name of Recipient Smith Godios Sorensen Inc.
Cleveland Clinic Nevada facilities	Address 411 Wolf Ledges Pkwy Ste 400 City/State Akron OH Zip 44311
NOTE: For release of medical records from Ashtabula County Medical Center (ACMC) and Cleveland Clinic Florida, your request must be made directly to ACMC or Cleveland Clinic Florida.	Phone Number (330) 762-6474 Fax Number (330) 762-7595
	Select one: X Paper Secure electronic delivery (If electronic, provide recipient's email): **OR FAX TO 330-762-7595**

Purpose for Disclosure: ___To assist in obtaining Social Security benefits
(Purpose for disclosure must be completed prior to processing. e.g., continuing care, personal use, legal)

Dates of service to release (FROM): _____ **(TO):** _____

Office Visits	History & Physical	Physical/Occupational Therapy Reports
Emergency Department Reports	Cardiac Reports	Homecare Records
Discharge Summary	Laboratory Reports	Radiation Oncology Records
Operative Reports	Radiology Reports	Other_____

I, the undersigned, authorize Cleveland Clinic to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. **This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* Release of Psychotherapy Notes requires a separate authorization.**
This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Health Information Management (see contact information below). Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information. There is no charge to send records directly to my health care provider.
If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

X_____ / _____ ____/____/____

*Signature of Patient/Patient's Personal Representative*** *Printed Name* *Date Signed*

_____
Relationship, if not Patient

**Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical records.*
***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (e.g., court appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of eighteen.*
***For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required to be submitted with the documents naming the administrator or executor of the estate.*

Submit request to one of the following:
(1) Health Information Management/Medical Record Department,
Health Data Services Ab-7
9500 Euclid Avenue, Cleveland, OH 44195
(2) Fax: 1-216-587-8043
(3) Email: IODDMROI@ccf.org
Questions? 1-844-203-8777

NOTICE: If you send health information to Cleveland Clinic via email, please know that your message may be sent in an unencrypted email. An unencrypted email means there is a risk that the information in the email and any attachments could potentially be read by a third party when it is sent through the internet.