Authorization Form to Release Information to SECURET TRUST

By signing this Authorization, I, ( ) the release of my individually-identifiable information maintained by: SOCIAL SECURITY & MEDICAID

My information may be disclosed under this Authorization to:

Name: SECURET TRUST

Address: 502 W Germantown Pike, Ste. 200 Plymouth Meeting, PA 19462

Specifically for the following purpose(s): _____ Resolve issue of losing benefits _____

_____

_____

This Authorization expires: _____

Insert applicable date (Month, Day, Year)

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my trust information.

Client's Signature _____ Date of Signature _____

Print Client's Full Name: _____

Client's Home Address: _____

Client's Home Telephone: _____ Date of Birth _____

When client is not competent to give consent, the signature of a parent, guardian Power of Attorney is required.

Signature of legal representative: _____ Date of Signature _____

Print Name: _____

Relationship of representative to client: _____

Optional: Photo ID# of Signature _____ Witness: _____

Client has been provided with a copy of the signed Authorization _____

Initials