6S12732474318896470320090609N1

New York State Office of Temporary and Disability Assistance
Division of Disability Determinations
P.O. BOX 5540
BINGHAMTON, NY 13902-9982

(518)473-7108 Toll Free: 1-800-522-5511 Ext. 7108 Fax: 1-866-667-3770
www.OTDA.State.NY.US/DDD 06/09/09

597460
21446428

In Reference to Claimant
MER ORDER #: F21DCAD10

CAYUGA MEDICAL CENTER AT ITHAC
101 DATES DRIVE
ITHACA, NY 14850

SSN: 431-88-9647 Date of Birth: 05/01/56
Name: KEVIN E SAUNDERS
Address: EPC 100 W WASHINGTON
ELMIRA, NY 14901

1388040300

This agency is responsible for adjudication of disability claims on behalf of the federal government under the Social Security Act. Your patient has made an application for benefits and we need medical evidence from treating sources to evaluate the claim. Attached is a signed consent for the release of the information. If you receive this request via system-generated FAX, we have retained the consent form in our file.

We would appreciate information from your records that is requested on the second page. This would enable us to evaluate the impairment in terms of the standards of this program.

Your cooperation is appreciated.

Sincerely yours,
B. SEELEY
Disability Analyst - Unit S127

****PLEASE FOLLOW INSTRUCTIONS TO RECEIVE PAYMENT****

VOUCHER INSTRUCTIONS: **Billed Amount: $10.00**
We are authorized to pay for medical information which is useful and relevant. If you wish payment, please **COMPLETE ALL BOXES BELOW or REVIEW PREPRINTED INFORMATION. Preprinted information needing correction must be authorized via signed correspondence on the facility letterhead and returned with this letter.**
Payee ID: Enter the **9-Digit Federal ID** assigned to you as an employer. If you are operating as an individual in business, enter your Social Security Number. **The ID number MUST belong to the payee.**
Payee Name: Enter your name and address **AS YOU WISH IT TO APPEAR ON THE CHECK.** **Task# 03**

Payee ID: 650765287	**Payee Certification:** I certify that the above is just, true and correct and that no part thereof has been paid except as stated and that the balance is actually due and owing, and that taxes from which the State is exempt are excluded.
Payee Name: iod incorporated	
Address: PO Box 19058	
Address: Green Bay, WI 54307-9058	**Payee's Signature in ink:**
City, State, ZIP	Title: COPY Date: 6/30/09

Off. Use Only: RO Signature/Date: CO - Signature/Date/Interest:

PLEASE RETURN THIS LETTER WITH YOUR REPLY IN THE ENCLOSED ENVELOPE OR FAX TO THE NUMBER ABOVE

2088301110020096

Claimant's Name: KEVIN E SAUNDERS
Date of Birth: 05/01/56

INFORMATION REQUEST

PSYCHOLOGICAL TESTING
DISCHARGE SUMMARY
CLINIC NOTES

ADMISSION HISTORY
ER-RECORDS
PSYCHIATRIC

Dates of treatment	OUTPATIENT	FIRST INPATIENT	MOST RECENT INPATIENT
		04/27/02 TO 05/02/02	04/27/02 TO 05/02/02

0597460 MR# 6434933 TRANSACTION#

BILL TYPE	INFORMATION RELEASED	
___ APS	___ D/S	___ ER/UC
___ DDB	___ H&P	___ LAB
___ HRF/NB	___ CONSULT	___ RADIOLOGY
___ LGL (CC#)	___ OP REPT	___ EEG/EMG/EKG
___ PATIENT	___ PATH/CYTOL	___ ECHO/STRESS
___ PROJECT	___ ADMIT NOTE	___ PT/ST/OT
___ STANDARD	___ RTW	___ IMMUN/GROWTH
___ STD CERT	___ PROG NOTES	___ MED/PROBLEM
___ WC	___ PSYCH/AODA	___ NB REC
___ WC AUTH		ABS ___ ENTIRE RECORD
___ OTHER	___	___ MISC

TAX YES NO CERTIFIED ___

___ DATE HONORED 16 PP ___ FP ___ DP
DATES(S) OF INFO SENT (OLDEST TO NEWEST)

Form Approved OMB No. 0960-0623

WHOSE Records to be Disclosed

NAME (First, Middle, Last) 6470320090609N1*

KEVIN ERIC SAUNDERS

SSN 431-88-9647 | Birthday (mm/dd/yy) 05/01/1956

NAME AND ADDRESS OF SOURCE
CAYUGA MEDICAL CENTER AT ITHAC
101 DATES DRIVE
ITHACA, NY 14850

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: SEE ABOVE
   - 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 venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS); and tests for HIV.
   - 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
- 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 ▶ [signature]

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		
5/22/09	1668 TRUMANSBURG RD		
Phone Number (with area code)	**City**	**State**	**ZIP**
(607) 277-5808	ITHACA	NY	14850

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶ [signature]

Phone Number (or Address) 320 ... ITHACA NY

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.

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1388.04.03.0.00

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Claimant's Name: KEVIN E SAUNDERS
Date of Birth: 05/01/56

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INDIVIDUAL authorizing disclosure | ☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)

SIGN ▶ [signature]

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed: 5/22/09 | Street Address: 1668 TRUMANSBURG RD

Phone Number (with area code): (607) 277-5808 | City: ITHACA | State: NY | ZIP: 14850

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶ [signature] | IF needed, second witness sign here (e.g., if signed with "X" above) **SIGN ▶**

Phone Number (or Address): 10 N Z ITHACA NY | Phone Number (or Address)

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Howell-Seeley, Cathy

From: Dean, Robert C. MD
Sent: Wednesday, June 17, 2009 5:37 PM
To: Howell-Seeley, Cathy
Subject: RE: REQUEST FOR MEDICAL RECORDS

OK to release. RCD

From: Howell-Seeley, Cathy
Sent: Tuesday, June 16, 2009 1:56 PM
To: Dean, Robert C. MD
Subject: REQUEST FOR MEDICAL RECORDS

Dr. Dean,

We have a request for medical records from NYS Disability on Kevin Saunders----597460---4/27/02 to 5/2/02 for his disability.

They are requesting a copy of DS, HP, ER, Clinic notes, and any psychological testing. Is this ok to release?

Thank you,

Cathy Howell-Seeley

Health Information Assistant

607-274-4314