

**DISABILITY REPORT - FIELD OFFICE - Form SSA-3367**

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**(3367) ID/Prior Filings**

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**Identifying Information**

1. Name of Person whose Social Security Record this Claim is being filed:

**Ricardo** [REDACTED]

His or Her Social Security Number: [REDACTED]

Name of Claimant (if different from above):

SSN (if different from above):

Gender: **Male**

Date Of Birth: [REDACTED] **1973**

2. Claimant's Alleged Onset Date: **03/18/2004**

3. Potential Onset Date (if different from above):

4. Reason for Potential Onset Date:

5. Explanation for Potential Onset Date, when applicable:

**Miscellaneous Information**

6. Protective Filing Date:

Date Last Insured (DIB/Freeze case):

Beginning of Prescribed Period (DWB):

End of Prescribed Period:

Controlling Date:

Closed Period Case: **No**

**Prior Filing Information**

7. Prior Filing(s): **No**

If Yes, and you are not sending the prior folder, enter the following:

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**(3367) Presumptive**

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The Presumptive Disability page details are not being displayed here because there is no

**WHOSE Records to be Disclosed**

Form Approved  
OMB No. 0960-0623

NAME (First, Middle, Last)

Wilbert Case

SSN

Birthdate  
(mm/dd/yy)

1996

**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:

- 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)
- Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
- 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.
- 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 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** IF not signed by subject of disclosure, specify basis for authority to sign  
 Parent of minor  Guardian  Other personal representative (explain)

**SIGN** ▶

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

Date Signed	Street Address		
	WAY		
Phone Number (with area code)	City	State	ZIP
555-5555	RICHMOND	VA	

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

**SIGN** ▶

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

Phone Number (or Address)	Phone Number (or Address)
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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.

**DISABILITY REPORT - ADULT - Form SSA-3368**

**(3368) Section 1 - Information About the Disabled Person**

A. Name: **Jimmy** [REDACTED]

B. Social Security Number: [REDACTED]

C. Daytime Telephone Number (If you do not have a number where we can reach you, give us a daytime number where we can leave a message.):

[REDACTED] 7777 Your number

D. Give the name of a friend or a relative that we can contact (other than your doctors) who knows about your illnesses, injuries, or conditions and can help you with your claim.

E. What is your height without shoes? **5' 9"**

F. What is your weight without shoes? **150 lbs.**

G. Do you have a medical assistance card? **No**

If "YES", show the number here:

H. Can you speak and understand English? **Yes**

If "NO", what is your preferred language?

NOTE: If you cannot speak and understand English, we will provide an interpreter, free of charge.

If you cannot speak and understand English, is there someone we may contact who speaks and understands English and will give you messages?

(If "YES", is this the same person as in "D" above? If it is, show "SAME" below, if not complete below.)

I. Can you read and understand English? **Yes**

J. Can you write more than your name in English? **Yes**

**(3368) Section 2 - Your Illnesses, Injuries, or Conditions and How They Affect You**