

**HEALTH AND SOCIAL SERVICES**  
**P.O. Box 1110**  
**Tampa, Florida 33601-1110**  
**(813) 272-5040 (FAX) 276-2865**

**DISABILITY DETERMINATION PROGRAM**  
**MEDICAL EXAMINATION AGREEMENT**

Case Number: \_\_\_\_\_ Date: \_\_\_\_\_

Case Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

You have been selected for special help in developing your application for Social Security/Supplemental Security Income (SSI) benefits. The Health and Social Services Dept (department) will pay to have your medical records assembled and reviewed as well as provide for any special medical tests you may need in order to determine if you will qualify for benefits. If you qualify, your application should be processed by Social Security more quickly than normal.

You will be contacted shortly by the Hillsborough HealthCare nurse who will help coordinate your activities in this special program.

It is very important that you keep all appointments and participate fully. By taking part in this program you will gain greatly, however, choosing not to cooperate may have an unfavorable effect on your Social Security/SSI application and result in denial of further County services.

I, \_\_\_\_\_ understand and agree:  
(Print Client Name)

1. That I am responsible for attending all medical appointments scheduled by Health and Social Services or its designated medical provider.
2. That failure to keep a scheduled appointment will result in the termination of my County provided Medical and General Assistance services.
3. To the disclosure of protected health information including medical and/or psychiatric, social, psycho-social and any HIV/AIDS and/or drug or alcohol related information and employment information between the department and its agents and contractors, and the Social Security Administration, to include any legal counsel retained by the claimant for the purpose of representation in his or her claim for disability benefits. I also agree to execute all necessary authorization forms to allow for this disclosure by third parties.
4. That failure to comply fully with the terms of this signed agreement shall result in the loss of my Medical and/or General Assistance Services.
5. That termination of services will be effective on the last day of the month in which the missed appointment was scheduled.

\_\_\_\_\_  
(Client's Original Signature)

\_\_\_\_\_  
(Date Signed)

**WORKER:** \_\_\_\_\_

**PHONE NO:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**FAX NO:** \_\_\_\_\_

**FACILITY:** \_\_\_\_\_