"This institution is an Equal Opportunity Provider"

Form Approved
OMB No. 0960-0566

Social Security Administration

Consent for Release of Information

TO: Social Security Administration

_____	_____	_____
Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
_____	_____
_____	_____
_____	_____
_____	_____

I want this information released because:

_____

_____

(There may be a charge for releasing information.)

Please release the following information:

____ Social Security Number

____ Identifying information (including date and place of birth, parents' names)

____ Monthly Social Security benefit amount

____ Monthly Supplemental Security Income payment amount

____ Information about benefits/payments I receive from _____ to _____

____ Information about my Medicare claim/coverage from _____to _____

(specify) _____

____ Medical records

____ Record(s) from my file (specify) _____

_____

____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if minor) or legal guardian. I know that if I make any representation, which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____

(Show signature, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____