

Service Provider _____
Name of Staff (Please Print) Agency Name

Customer's Name _____

Date of Birth _____ Social Security Number _____

I authorize SSA to release the dates and status of my Social Security Disability Insurance and/or Supplemental Security Income application(s), to:

(Service Provider) (fax #)

This consent for release of information is in effect from _____ to _____ (not to exceed 1 year).
(MMDDYY) (MMDDYY)

I want this information released because I am pursuing entitlement to Social Security disability programs.

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information that I provided on this form and that it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: _____ Relationship: _____
(Below, show signatures, names, and addresses of two people if signed by mark.)

Date: _____

Witness #1

(Print Name)

(Signature)

(Address)

(City, State, and Zip code)

Witness #2

(Print Name)

(Signature)

(Address)

(City, State, and Zip code)