Social Security Administration

Form Approved
OMB No. 0960-XXXX

AUTHORIZATION TO RELEASE MEDICAL REPORT TO PHYSICIAN

If you want a copy of the examination or test sent to your doctor, please fill in your doctor's name and address, your address and telephone number, sign and date the form and return it in the enclosed preaddressed envelope.

Claimant: [CLMT NAME]
SSN: [CLMT SSN]
Service Request Number: [SR NUMBER]

TO: Office of Medical and Vocational Expertise

I, [CLMT NAME] , hereby authorize the release of a copy of the medical report of my consultative examination/test performed by [CE VENDOR NAME] to:

_____
Your Personal Physician

_____
Street Address

_____
City, State & Zip Code

I understand that this authorization is valid for either 90 days from the date signed or until acted upon, whichever occurs first, unless revoked in writing by me.

_____ _____
Your Signature Date

_____ _____
Your Street Address Your Telephone Number

_____
Your City, State & Zip Code

ATTN: [CASE MANAGER NAME]
[TITLE]

PRIVACY ACT/PAPERWORK REDUCTION ACT NOTICE

The information requested on this form is authorized by the Social Security Act, Title 20 CFR 401.55 and 401.100. Your authorization is needed to release copies of the consultative examination report and/or test results to your personal physician. The information you provide on this form will be used to send the consultative examination and/or test results to your personal physician. Information requested on this form is voluntary. However, if you do not provide the required information, we will be unable to fulfill your request to send the consultative examination report and/or test results to your doctor. While the information you furnish on this form would almost never be used for any purpose other than sending the consultative examination and/or test results to your personal physician, such information may be disclosed by SSA for the following purposes (1) to assist SSA in determining the right to Social Security benefits for yourself or another person; (2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of programs administered by SSA, and (3) to comply with laws and regulations requiring the exchange of information between SSA and another agency.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security Office.

PAPERWORK REDUCTION ACT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 5 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to*: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Only comments relating to our time estimate should be provided, not the completed form.***