SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0761

REQUEST TO RELEASE MEDICAL REPORT TO A HEALTH CARE PROVIDER

TO: Office of Medical and Vocational Expertise

If you want a copy of the consultative examination/test performed on [CE DATE] sent to your health care provider, complete Sections A and C. If you are a parent or legal guardian making this request, complete Sections B and C. Be sure to include your address and telephone number and return the form in the enclosed preaddressed envelope.

SECTION A - For Claimants

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

_____ Health Care Provider Name

_____ Street Address

_____ City, State, Zip Code

SECTION B - For Parents and Legal Guardians

A parent or legal guardian requesting a copy of a medical record *must* designate a physician or other health care professional to receive the record. The minor's medical record will not be disclosed directly to you.

Claimant: [CLMT NAME]
SSN: [CLMT SSN]

I, [PARENT / LEGAL GUARDIAN], designate the following physician/health care professional to receive a copy of the consultative examination/test performed by [CE VENDOR NAME].

_____ Health Care Provider Name

_____ Street Address

_____ City, State, Zip Code

SECTION C

I understand that this request is valid for either 90 days from the date signed or until SSA sends the report as requested.

_____ _____
Your Signature Date

_____ _____
Your Street Address Your City, State, Zip Code

_____
Your Telephone Number

ATTN: [CASE MANAGER NAME]
[TITLE]

PRIVACY ACT NOTICE

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 1631(d)(1) and 1631(e)(1) of the Social Security Act. Your signed request is needed to release copies of the consultative examination report and/or test results. The information you provide on this form will be used to send the consultative examination and/or test results to the health care provider you specify. Information requested on this form is voluntary. However, if you do not provide the required information, we will be unable to fulfill your request. 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 treating source, 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.***