i3368 screenshots

Medical Release Page

Social Sec	urily Online		Λdult	Disabili	ty Report			
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Kelly G. Anderson	xxx-xx-1234							
Overview	Identificatio	on Medical	We	rk/Education	Remarks	Review	Submit	_
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Medical F	Release Fo	rm						
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Yes path

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sty G. Anderson Overview	xox iox 1204 Identification	n Medica	Work/Edu	ucation	Remarks	Review	Submit	
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No Path

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Medical Release Form in popup window



Social Security Online www.socialsecurity.gov Adult Disability Report

Print this page...

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

** PLEASE READ THE ENTIRE FORM BEFORE SIGNING **

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange): OF WHAT All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:

 Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)

- Drug abuse, alcoholism, or other substance abuse
- Sickle cell anemia
- Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records
 of HIV/AIDS
- Gene-related impairments (including genetic test results)

2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.

3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.

4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

 All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities

- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

то whom

The Social Security Administration and to the State agency authorized to process my case (usually called "disability determination services"), including contract copy services, and doctors or other professionals consulted during the process. [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE

Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

EXPIRES WHEN

This authorization is good for 12 months from the date signed (below my signature).

 I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.

 I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).

I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).

 SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed

I have read the entire form and agree to the disclosures above from the types of sources listed.

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827, "Authorization to Disclose Information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by SSA is protected by the Privacy Act of 1974. Once medical information is disclosed to SSA, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). SSA retains personal information in strict adherence to the retention schedules established and maintained in conjunction with the National Archives and Records Administration. At the end of a record's useful life cycle, it is destroyed in accordance with the privacy provisions, as specified in 36 CFR part 1228.

SSA is authorized to collect the information on form SSA-827 by sections 205(a), 223(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(1) and 1631 (e)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility, or continuing eligibility, for benefits, and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in SSA. In some cases, your information may also be reviewed by SSA personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by SSA without your consent if authorized by Federal laws such as the Privacy Act and the Social Security Act. For example, SSA may disclose information:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist SSA to establish rights to Social Security benefits and/or coverage;

 Pursuant to law authorizing the release of information from Social Security records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs(VA));

3. For statistical research and audit activities necessary to ensure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract with SSA).

SSA will not redisclose without proper prior written consent information: (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from 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 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING IN THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-326-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send **only** comments relating to our time estimate to this address, not the completed form.

Form SSA-827 (4-2009) ef (04-2009) Use 2-2003 and Later Editions Until Supply is Exhausted

Review

	urily Online	Δ	dult Disabilit	ty Repo <mark>rt</mark>			
Gely C. Anderson	ascardy.gov						
Overview	Identification	Medical	Work/Education	Remarks	Review	Submit	
Review					•		
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Review			and for the second s	una lulas			
	ortunity to review the an ler you submit your repo		ovided thus far. You will	te græn en opport	unity to print your		
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identificat							
	itto: Kell Ly. G Ander rity Number, 988-77-1						
	Pebruary 19, 196						
Report Comp	leter						
Edi 1	an completing th	te disability	report for syself				
Applicant's P	Service and Information						
P N	When Names Used on M hefened Language, Bas Jaling Address: 400, cs Jaytime Phone, 410–64	lish thedral Stree	nai Rotonia: Na n., Apt. VA., Delitina	we, MD 21201			

	Alternate Phone: 443-799-6692
Reentry N	lumber
	Reentry Number#: D94217143
Other Co	ntact
Edit	Name: Chris Anderson Relationship: Husband or Wife Mailing Address: 400 Cathedral Street, Apt 7A, Baltimore, MD 21201 Daytime Phone: 866-867-5309 Preferred Language: English

Back to Top

Medical	
Condition	S
Edit	List of physical and mental conditions: 1: type 2 diabetes 2: heart disease 3: copp Height without shoes: 5 feet, 8 inches Weight without shoes: 260 pounds Conditions cause pain or other symptoms: Yes Seen a healthcare provider or received treatment, or have an appointment scheduled: For physical conditions: Yes For mental conditions: Yes
Doctors a	nd Other Healthcare Professionals
Edit	Doctor/Professional #1: Dr. Samantha Gupta Office Name: Physicians Associate Group Address: 900 Caton Avenue, Suite 301, Catonsville, MD 21229 Phone: 410-496-9643 Reason for visits: diabetes, heart disease, COPD Treatments received: blood pressure and breathing monitored First visit: 2001 Last visit: 03/2011 Next scheduled appointment: None
Edit	Doctor/Professional #2: Dr. Elijah Saunders Address: 2200 Kernan Drive, Room 4611, Baltimore, MD 21207 Phone: 410-328-4266

Reason for visits: depression, pain management Treatments received: therapy First visit: 11/2008 Last visit: 06/2011 Next scheduled appointment: 08/2011
Add Doctor/Healthcare Professional
Hospitals and Clinics
Edit Hospital/Clinic #1: Union Memorial Hospital Address: 201 East University Parkway, Suite 226, Baltimore, MD 21218 Phone: 410-554-2532 Inpatient Stays: Date In: 03/2011 Date Out: 03/2011 Outpatient Visits: None Emergency Room Visits: First visit: 2009 Last Visit: 2011 Reason for visits: heart surgery, couldn't breathe well Treatments received: surgery
Edit Hospital/Clinic #2: Vancouver General Hospital Address: 855 West 12th Avenue, Vancouver, Canada V5Z 1M9 Phone: 604-875-4111 Inpatient Stays: None Outpatient Visits: None Emergency Room Visits: 10/2010 Reason for visits: thought I was having a heart attack Treatments received: observation
Add Hospital/Clinic
Tests
Edit Test #1: EKG Sent for test by: Doctor at Vancouver General Hospital Date of test: 10/2010
Edit Test #2: X-Ray Test Description: chest Sent for test by: Doctor at Vancouver General Hospital Date of test: 10/2010
Add Test

Medicine	3
Edit	Medicine #1: Singulair
	Reason: for breathing
	Prescribed by: Dr. Samantha Gupta
Edit	Medicine #2: Plavix
	Reason: a blood thinner
	Prescribed by: Dr. Samantha Gupta
Edit	Medicine #3: Cymbalta
Lun	Reason: for depression
	Prescribed by: Dr. Elijah Saunders
Edit	Medicine #4: Tylenol
Luit	Reason: for pain
	Prescribed by: Dr. Elijah Saunders
Add N	ledicine
Other Me	dical Records
Edit	No Other Medical Records listed
Add I	/ledical Record
Medical F	lelease
Edit	I have read and agree to sign the Medical Release Form

Back to Top

Work/E	lucation
Introducti	on
Edit	Currently working? No, I have never worked
Work Acti	vity
Edit	Date became unable to work: 03/04/2011
Job Histor	у
	Not applicable
Education	
Edit	Highest grade of school completed: 12th grade Approximate date completed: 1986 Any special training, trade, or vocational school: No Special education classes or other education services: No

Back to Top

Remarks	
Remarks	
Edit None	

Back to Top

[S]ign Off (finish later)

<< [P]revious

[N]ext >>

Submit

1	Social Sec	curity On	line		Adult Disa	bility Rep	oorl		
S.	www.socia	isecurity.g	ov						
Kelly C	3. Anderson	2000 200	1234						
Ov	ervlew	Identif	leation	Medical	Work/Education	Remarks	Review	Submit	
Print	ing hatmet	iana 👘	Submit	Receipt	Next Steps				
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Submit Adult Disability Report and Sign Medical Release Form

You are ready to submit this report and sign the medical release form. If you were not able to complete all parts of the report, don't worry. We will contact you if we need any more information.

Funderstand and agree that my Medical Release Form will be signed by selecting "Submit" below. Edeclare under penalty of periory that I have read and examined all the information and it is true and connect to the best of my knowledge. I understand that anyone who knowledge gives a false statement, or causes someone clae to do so, commits a crime and may be sent to prison or may face other penalties, or both.

IMPORTANT. When you select "Submit", you are submitting the Medical Release Form and the Adult Disability Report to the Social Security Administration. Your name and the date will display in the Medical Release Form's signature box. This electronic signature is a substitute for your handwritten signature. You will NOT be able to come back online to this report or the Medical Release Form after you press the Submit button.

[S]ign Off (finish later)

<< [P]nevious

Submit

Receipt

		1	\dult Disabilit	ty Report		
Kely G. Anderson Overview	xxx-rx-1234 Identification	Medical	Work/Education	Remarks	Review	Submit
Printing Instructions Submit		Receipt	Next Steps			
		-				Next

Receipt for Your Records

Thank you for completing this disability report. This is your receipt-

Print or save this page for your records, if you choose to save this page, save it as a file and not as a bookmark. <u>Note life</u>

😹 Print this page

Your Online Adult Disability Report and esigned and dated Medical Release Form were received on June 8, 2011 at hhommoss Eastern Time. We will process them at your local Social Security Office.

What to Expect

It takes about 120 days to make a disability decision. Every case is different. We may take more or less time on your case.

- We may contact you for more information while we work on your case.
- If we need more medical evidence, we may ask you to see a doctor for a special exam free of charge.

Contact us immediately if you:

- A change of address or phone number.
- Visit to a new doctor
- A new medical test.
- A change in medical condition
- A change in work activity.

To Contact Social Security:

- Call our toil-tree number, 1-800-772-1213. It you are deat or hard of hearing, call our toil tree "LLY" number, 1-800-326-0778.
- Representatives are available blonday through Enday from / a in to / p m , or Contact your local Social Security office at the address below

SOCIAL SECURITY ADMINISTRATION 1010 Park Ave Suite 200 Baltimore, MD 21201 (866) 931-9942

Identification

Applicant Name: Kelly G. Anderson Social Security Number: 988-77-1234 Date of birth: February 19, 1968

Report Completer

I am completing this disability report for myself

Applicant's Personal Information

Other Names Used on Medical or Educational Records: No Preferred Language: English Mailing Address: 400 Cathedral Street, Apt 7A, Baltimore, MD 21201 Daytime Phone: 410-644-3211 Alternate Phone: 443-799-6692

Other Contact

Name: Chris Anderson Relationship: Husband or Wife Mailing Address: 400 Cathedral Street, Apt 7A, Baltimore, MD 21201 Daytime Phone: 866-867-5309 Preferred Language: English

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Medical

Conditions

List of physical and mental conditions: 1: type 2 diabetes 2: heart disease 3: COPD 4: depression Height without shoes: 5 feet, 8 inches Weight without shoes: 260 pounds Conditions cause pain or other symptoms: Yes **Doctors and Other Healthcare Professionals**

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Tests	
	Test #1: EKG
	Sent for test by: Doctor at Vancouver General Hospital
	Date of test: 10/2010
	Test #2: x-Ray
	Test Description: chest
	Sent for test by: Doctor at Vancouver General Hospital
	Date of test: 10/2010
Medicines	
	Medicine #1: Singulair
	Reason: for breathing
	Prescribed by: Dr. Samantha Gupta
	Medicine #2: Plavix
	Reason: a blood thinner
	Prescribed by: Dr. Samantha Gupta
	Medicine #3: Cymbalta
	Reason: for depression
	Prescribed by: Dr. Elijah Saunders
	Medicine #4: Tylenol
	Reason: for pain
	Prescribed by: Dr. Elijah Saunders
Other Mee	lical Records
	No Other Medical Records listed
Medical R	elease
	I have read and agree to sign the Medical Release Form

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Work/Education
Introduction
Currently working? No, I have never worked
Work Activity
Date became unable to work: 03/04/2011
Job History
Not applicable

Education

Highest grade of school completed: 12th grade
Approximate date completed: 1986
Any special training, trade, or vocational school: No
Special education classes or other education services: No

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Remarks	
Remarks	
None	

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Medical Release	
Medical Release Form	
	WHOSE Records to be Disclosed Form Approved OMB No. 0860-0623 NAME (First, Middle, Last) Kelly G Anderson SSN 988-77-1234 Birthday (mm/dd/yy) 02/19/68
AUTHORIZATION TO DISC	CLOSE INFORMATION TO
THE SOCIAL SECURITY	
** PLEASE READ THE ENTIRE FORM, BOT	
I voluntarily authorize and request disclosure (including p	
	ords and other information related to my ability to
perform tasks. This includes specific permission to relea 1. All records and other information regarding my treatment, hospitaliz	<u>SC:</u> ration_and outpatient care for my impairment(s)
including, and not limited to:	autori, and outputteric care for my impairment(of
 Psychological, psychiatric or other mental impairment(s) (excludes " 	psychotherapy notes" as defined in 45 CFR 164.501)
 Drug abuse, alcoholism, or other substance abuse Sickle cell anemia 	
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 Information about how my impairment(s) affects my ability to compl 3. Copies of educational tests or evaluations, including Individualized 	
speech evaluations, and any other records that can help evaluate funct	
4. Information created within 12 months after the date this authorization	
FROM WHOM	
 All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including THIS BOX TO BE COM the subject (e.g., other 	PLETED BY SSA/DDS (as needed) Additional information to identify names used), the specific source, or the material to be disclosed:
mental health, correctional, addiction	
treatment, and VA health care facilities	

records adm Social worke Consulting e Employers, i compensatio Others who	may know about my condition hbors, friends, public officials) The Social Security Admi determination services", ir process. [Also, for internal Determining my eligibility	inistration and to the State a cluding contract copy serv ional claims, to the U.S. Depa for benefits, including lookin	agency authorized to process my c ices, and doctors or other professi artment of State Foreign Service Post g at the combined effect of any impa lity, and whether I can manage such I	ionals consulted	
			enefits ONLY (check only if this ap	oplies)	
			late signed (below my signature).		
I understand I may write t SSA will give I have read	I that there are some circumst to SSA and my sources to reve e me a copy of this form if I as both pages of this form and	ances in which this informatic oke this authorization at any t k; I may ask the source to alk I agree to the disclosures a	ow me to inspect or get a copy of mat bove from the types of sources list	s (see page 2 for o terial to be disclos ted.	ed.
	USING BLUE OR BLAC		ed by subject of disclosure, spe of minor 🔲 Guardian 🔲 Othe	city basis for a r personal repre	
	authorizing disclosure		(expl		
SIGN 🕨 🖪	Kelly G Anderson	(i arenuguarular	n/personal representative sign atures required by State law)		
Date Signed 06/06/2	2011 10:27 am	Street Address 400 0	Cathedral Street, A _l	pt 7A	
Phone Number ((410) - 64		City Baltimor	e	State MD	ZIP21201
WITNESS	I know the person sign	ing this form or am satisfie	d of this person's identity:		
SIGN 🕨			IF needed, second witness sign here	e (e.g., if signed v	vith "X" above)
Phone Number	(or Address)		Phone Number (or Address)		
other information		"); 45 CFR parts 160 and 164	with the provisions regarding disclos ; 42 U.S. Code section 290dd-2; 42 0 s 99 and 300; and State law.		
	4-2009) ef (04-2009) Use 2-20				Page1 of 2
	"Authorization to I	Explanation of F Disclose Information to tl	orm SSA-827, he Social Security Administrati	ion (SSA)"	
of managing be	written authorization to he enefits. Laws and regulation	lp get the information require that sources of	uired to process your claim, and t personal information have a sign elease of information about certa	to determine you led authorization	n before

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if

educational sources.

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SSA is authorized to collect the information on form SSA-827 by sections 205(a), 223(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(1) and 1631 (e)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility, or continuing eligibility, for benefits, and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in SSA. In some cases, your information may also be reviewed by SSA personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by SSA without your consent if authorized by Federal laws such as the Privacy Act and the Social Security Act. For example, SSA may disclose information:

- To enable a third party (e.g., consulting physicians) or other government agency to assist SSA to establish rights to Social Security benefits and/or coverage;
- Social Security benefits and/or coverage, 2. Pursuant to law authorizing the release of information from Social Security records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs(VA));
- For statistical research and audit activities necessary to ensure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract with SSA).

SSA will not redisclose without proper prior written consent information: (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from 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 <u>Paperwork Reduction</u> <u>Act of 1995</u>. 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 10 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING IN THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

Form SSA-827 (4-2009) ef (04-2009)

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Next Steps not from iClaim

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Kelly C. Anderson — cxc-x	- 1234						
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1010 Park Ave							

Suite 200 Baltimore, MD 21201 (866) 931 -9942

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Next Steps from iClaim

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Steps in the Disability Claim Process:

- · Disability Application You have sheady completed the Disability Application
- Disability Report (about 90 minutes) you provide us with your medical and work history
- Medical Release Form (about 5 minutes) you allow us to get information from your declars.

Note: Print and review the Adult Disability Checklist so you know what information you need to begin the Disability Report. (The Adult Disability Checklist requires <u>Adobe Resder</u> to open and print it.)

If you have not already done so, refer to <u>How to Move Arcond in This Report</u> to understand how to navigate and work with the Disability Report

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