

i3441 screenshots

About the Request for Reconsideration page (*Updated screen*)

Social Security Online
www.socialsecurity.gov

Name: John Public
SSN: XXX-XX-6633

Internet Appeal

About the Request for Reconsideration

OMB No. 0960-0022

FIRST APPLICANT: The letter you received about our determination on your case lets you about your right to request a reconsideration of our determination on your case. To request this review, you need to complete an SSA 561-U2, Request for Reconsideration. The next few pages allow you to electronically complete and submit the SSA 561. The last page of Part 1 is a Receipt page with a date and time confirmation that you should print and save for your records.

NOTE: You should mail any information you have that shows our original determination was not correct to the Social Security Office address provided at the end of Part 2. You should also complete the SSA-3441, Disability Report - Appeal, and the Medical Release Form, Authorization to Disclose Information to SSA. The Appeal Disability Report (SSA 3441) is Part 2 of this Internet Appeal Process, and it includes a link to the Medical Release Form.

You may also need to complete a form SSA 1696, Appointment of Representative, if you are appointing a representative. If your representative is not an attorney, he or she must sign the SSA 1696 or state in writing that he or she accepts the appointment, before you send it to us. Both the Appeal Request Receipt page and the Appeal Disability Report include a link to the SSA 1696.

If you have questions, you may call our toll-free number 1-800-772-1213 (TTY 1-800-825-0778), or contact your local Social Security Office. When you contact us, be sure to have any other we sent you. It will help us answer your questions.

We estimate you will need 20 minutes to complete this Request for Reconsideration. If you want more information, use this link to read about the [Payment Reduction Act](#).

If you want to file your request for review online, please select the Continue button to go to the next page. If you choose not to complete your request online, please select the Exit button to leave this appeal process.

USA.gov [Privacy Policy](#) [Website Privacy & Online Access Information](#) [Site Map](#) [www.Larger 1.6x72](#)

YES path

Review and send: Medical Release Form page (New screen)

Social Security Online
www.socialsecurity.gov

Sign Out About You Medical History **Review and Send**

Name: John Public
SSN: xxx-xx-8888

Disability Report - Appeal

Review and send: Medical Release Form

To help us make a decision about your disability claim, we need to have medical information that shows you have a disability. The law requires us to have your signed Medical Release Form in order to get your medical records from your doctors, hospitals and other sources. We may not be able to approve your disability claim without this signed authorization.

You must review the entire [Medical Release Form](#) before agreeing to sign. The form contains information about how it will be used and explains the possible consequences of not signing the form.

Note: If you agree to sign the Medical Release Form, your name and the date will display in the form's signature box when you submit the Appeal Disability Report. This electronic signature is a substitute for your handwritten signature. You can print a copy of the signed and dated form upon submission.

I voluntarily authorize and request disclosure of all my medical records, also education records and other information related to my ability to perform tasks.

I have read and agree to sign the Medical Release Form

I DO NOT agree to sign the Medical Release Form

[Previous](#) [Continue](#)

[Content \(x\) How to Review and Send This Report](#)

YES path

Review and send: additional forms we need page *(New screen for eAuthorization users)*

Need to discuss the flow using 'Print Cover Sheet' button because this format differs from the current functionality of the application.

Social Security Online
www.socialsecurity.gov

Disability Report - Appeal

Name: John Public
SSN: xxx-xx-0535



Review and send: additional forms we need

Although you have sent the report to us online, you can help us make a faster decision on your application by providing us with any medical records you have. Please mail or bring them into your local Social Security office with the Cover Sheet.

What you need to do next if you have medical records:

1. Continue to the next page, which is the cover sheet.
2. Print a copy of the cover sheet (or two copies if you want to keep one).
3. Complete the "Name" block and date on the cover sheet.
4. Mark on the cover sheet what you are sending or bringing to Social Security.
5. Mail or bring the cover sheet and its attachments to Social Security at the address we will give you.

You may want to print an extra copy of each form to keep for your records.

What to do next if you do NOT have any additional forms or medical records:

Continue to the next page to finish submitting your Appeal Disability Report.

Print Cover Sheet

Continue

[Accessibility: How to Print Appeal Dis Report](#)

YES path

Review and send: print cover sheet page (*Updated screen for all users*)

Social Security Online
www.ssa.gov/online/

Disability Report - Appeal

Name: John Public
SSN: xxx xx 8535



Review and send: print cover sheet

Please print this page and mail or bring it to Social Security at the address shown below to submit all of the checked items for John Public.

John Public's address is:

555 Main Street
Anytown, MD 21087

John Public's daytime phone number is:

(410) 555-1212

Name and address of someone else Social Security can contact who knows about John Public's condition and can help with his or her appeal:

John Public
555 Main Street
Baltimore, MD 21087

I have attached the following items:

Check all that apply.

- Medical Release
- Medical Evidence
- [Appointment of Representative Form](#)
- [Waiver of Right to Personal Appearance Form](#)
- Other (Please list below)

Name of person completing this disability report: John Public

Date: April 1, 2011

Mail or bring to:

SOCIAL SECURITY ADMINISTRATION
915 N WASHINGTON ST
ROCKVILLE, MD 20850
(800) 833-6341

You can mail or bring these documents to a different Social Security Office. You can use the [Office Locator](#) to find another Social Security Office.

If you have printing problems:

Please try again. If you are still unable to print this page, please continue. Contact Social Security at the address and phone number we have provided to tell us that you could not print the Cover Sheet.

[Previous](#)

[Continue](#)

Contact Us | [How to Move Around This Report](#)

YES path

Confirmation page (*New screen for eAuthorization users*)

Social Security Online
www.socialsecurity.gov

Disability Report - Appeal

Name: John Public
SSN: xxx-xx-0535



Confirmation

Thank you.

We received your Appeal Disability Report and Medical Release Form on April 1, 2011 at 11:27:31 am Eastern Time. We will process it at your local Social Security Office (see address below).

We recommend you review this entire page and your signed Medical Release Form, then **print or save** it for your records.

If you have additional items to submit, mail or bring them to your local Social Security Office at the address below. Please include the completed cover sheet.

Your Local Social Security Office:

SOCIAL SECURITY ADMINISTRATION
315 N WASHINGTON ST
ROCKVILLE, MD 20850
(888) 620-5241

You can mail or bring these documents to a different Social Security Office. You can use the Office Locator to find another Social Security Office.

What to Expect:

- While we are processing your appeal, we may contact you for more information or to set up an interview. We may ask you to fill out additional forms.
- If we need more medical evidence, we may ask you to see a doctor for a special examination. We will pay for this.
- If you have copies of medical records that you have not given to us before, mail them to your local Social Security Office.
- Please contact Social Security immediately if you:
 - Go to a new doctor
 - Have a new medical test done
 - Have a change in your condition
 - Go to work
 - Change your address or phone number
- For more information on the disability process, go to [How the Disability Appeal Process Works](#).

Your Signed Medical Release:

WHOSE Records to be Disclosed		<small>Form Approved OMB No. 6030-0043</small>	
NAME (Print Name, Last)			
Kelly G Anderson			
SSN	988- 77 -1234	DATE (mm/dd/yyyy)	02/19/08

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

** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW **

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:

- 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) (includes "psychotherapy notes" as defined in 45 CFR 164.501)
 - Drug abuse, alcoholism, or other substance abuse
 - Stable cell events
 - Records which may indicate the presence of a communicable or noncommunicable disease, and tests for or records of HIV/AIDS
 - Genetic-related impairments (including genetic test results)
- Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
- 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.
- 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
- Employer, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/ODS (as needed) Additional information to clarify the subject (e.g., alias names used), the specific source, or the material to be disclosed.

TO 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.

Determining whether I am capable of managing benefits ONLY (check only if this applies)

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 source 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 both pages of this form and agree to the disclosures above from the types of sources listed.

PLEASE SIGN USING BLUE OR BLACK INK ONLY If not signed by subject of disclosure, specify basis for authority to sign

INDIVIDUAL authorizing disclosure

- Parent of minor Guardian Other personal representative (caption)

SIGN ▶ Kelly G Anderson

Print Name/Personal representative sign here if two signatures required by State law ▶

Date Signed	06/06/2011 10:27 AM	Street Address	410 Catharine Street, Apt 1A		
Phone Number (with area code)	(410) - 644-3211	City	Baltimore	State	MD
				ZIP	21201

WITNESS I know the person signing this form or am satisfied of this person's identity

SIGN ▶ IF needed, second witness sign here (e.g., if signed with "X" above)

Home Number (or Address)

Phone Number (or Address)

This product and special authorization to disclose info 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 88 and 99, and State law.

Form SSA-827 (4-2002) of (04-2002) Use 2-2005 and Later Editions Until Supply is Exhausted

Page 2 of 2

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 in the event 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 160 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). SSA retains personal information in strict substance 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 45 CFR part 1700.

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 (a)(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 in establishing rights to 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 health 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 program (e.g., to the Bureau of the Census and private concerns under contract with SSA).

SSA will not disclose 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. § 5107, 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 form, 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 1-800-772-1232 (TTY 1-800-325-4778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21275-6901. Send only comments relating to our time estimate to this address, not the completed form.

Form SSA-827 (4-2002) of (04-2002)

Page 2 of 2

Previous

Finished

Confirm (x) How to Review and This Report

NO then YES path


Review and send: Medical Release Form page

Social Security Online
www.ssa.gov/ssi/ssr/

Disability Report - Appeal

Sign Off About You Medical History **Review and Send**

Name: John Public
SSN: xxx-xx-0555

 **Review and send: Medical Release Form**

To help us make a decision about your disability claim, we need to have medical information that shows you have a disability. The law requires us to have your signed Medical Release Form in order to get your medical records from your doctors, hospitals and other sources. We may not be able to approve your disability claim without this signed authorization.

You must read the entire [Medical Release Form](#) before agreeing to sign. The form contains information about how it will be used and explains the possible consequences of not signing the form.

Note: If you agree to sign the Medical Release Form, your name and the date will display in the form's signature box when you submit the Appeal Disability Report. This electronic signature is a substitute for your handwritten signature. You can print a copy of the signed and dated form upon submission.

I voluntarily authorize and request disclosure of all my medical records, also education records and other information related to my ability to perform tasks.

I have read and agree to sign the Medical Release Form

I DO NOT agree to sign the Medical Release Form

[Click here to How to Review and Send This Report](#)

NO then YES path

Please confirm page (New screen)

Appeals Process



Please confirm

You chose **NO** to sign the Medical Release Form.

If you choose "No, I Do Not Agree", you may delay the processing of your disability claim. To help us make a decision about your disability claim, we need to have medical information that shows you have a disability. The law requires us to have your signed Medical Release Form in order to get your medical records from your doctors, hospitals and other sources. We may not be able to approve your disability claim without this signed authorization. By continuing with this choice, you will "send" the Appeal Disability Report and will have the opportunity to mail your signed Medical Release Form.

If you choose "Yes, I Agree", you will return to the previous page, and will be able to make the change.

Do you agree to sign the Medical Release Form?

NO then YES path – Radio button for I agree is pre-selected.
Review and send: Medical Release Form page

The screenshot shows the 'Disability Report - Appeal' page on Social Security Online. The user is identified as John Public with SSN xxx-xx-0555. The page title is 'Review and send: Medical Release Form'. The main content area contains the following text:

To help us make a decision about your disability claim, we need to have medical information that shows you have a disability. The law requires us to have your signed Medical Release Form in order to get your medical records from your doctors, hospitals and other sources. We may not be able to approve your disability claim without this signed authorization.

You must review the entire Medical Release Form before agreeing to sign. The form contains information about how it will be used and explains the possible consequences of not signing the form.

Note: If you agree to sign the Medical Release Form, your name and the date will display in the form's signature box when you submit the Appeal Disability Report. This electronic signature is a substitute for your handwritten signature. You can print a copy of the signed and dated form upon submission.

I voluntarily authorize and request disclosure of all my medical records, also education records and other information related to my ability to perform tasks.

I have read and agree to sign the Medical Release Form
 I DO NOT agree to sign the Medical Release Form

Navigation buttons: Previous, Continue

Footer: [Contact us | How to View Your This Report](#)

Then follows YES path described above.

No Path will continue to have the existing screen flow.

Medical Release Form – opens in new window

Appeals Process



Authorization to disclose information to the Social Security Administration (SSA)

Close this window to return to the appeal process.

**** 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 164.107)
- 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 worker/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)

TO 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. 101-191 (HIPAA), 45 CFR parts 160 and 164, 42 U.S. Code sections 2000d-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.471; 26 U.S. Code section 1232g ("HIPAA"); 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 acted 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 services 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 1278.

SSA is authorized to collect the information on form SSA-827 by sections 204(a), 224(d)(1)(A), 1614(a)(2)(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;
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));
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 disclose 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 1-800-328-0778).** You may send comments on our time estimate above to SSA, 1400 Security Blvd., Baltimore, MD 21285-6400. Send only comments relating to our time estimate to this address, not the completed form.

Form **SSA-827** (4-2009) of (04-2009) Use 2-2000 and Later Editions Until Supply is Exhausted

[Close this window to return to the appeal process.](#)