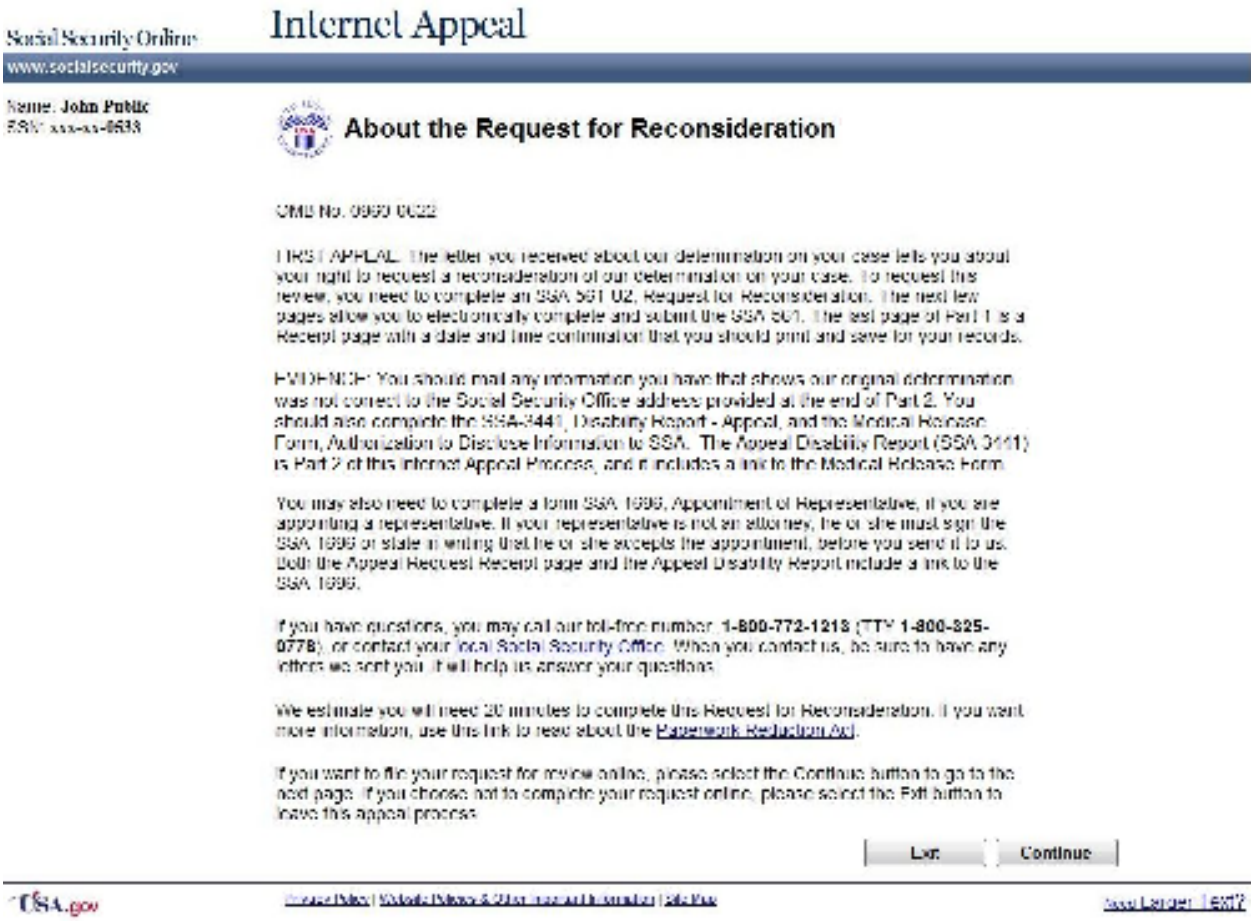
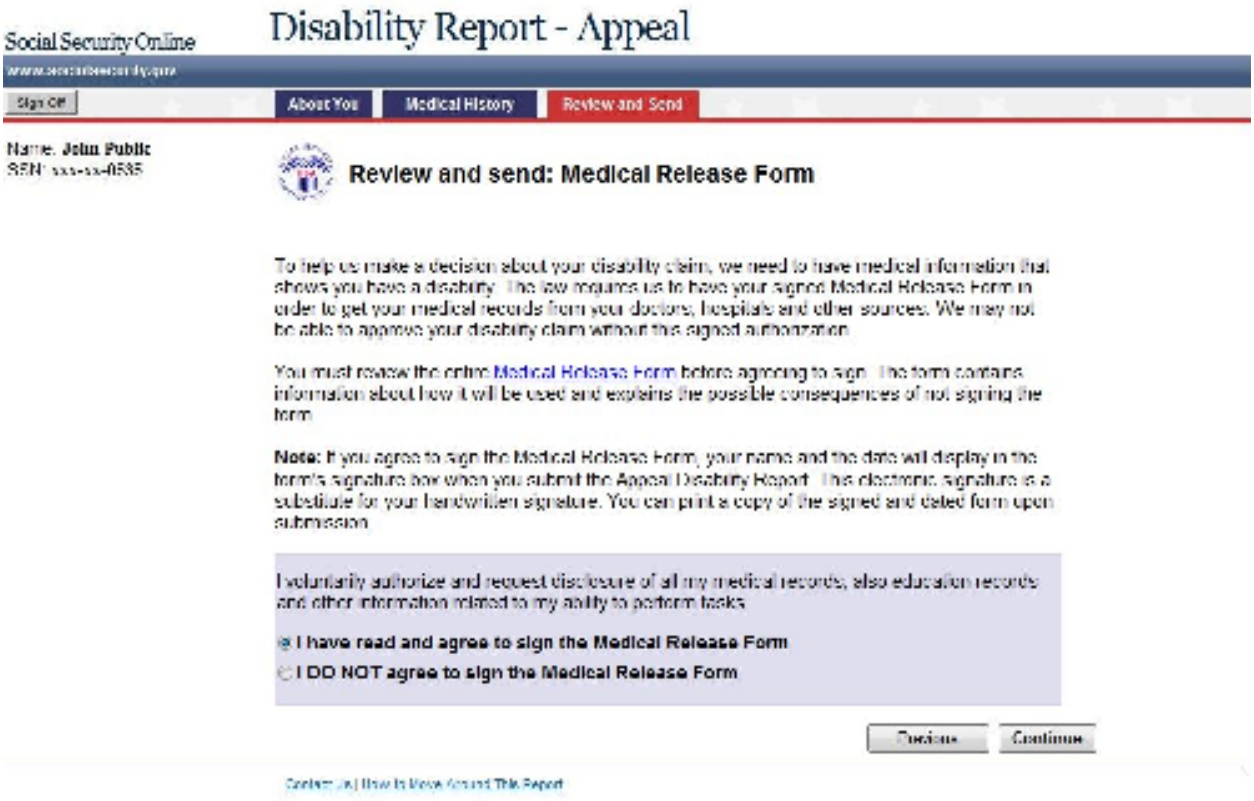
i3441 screenshots

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



YES path

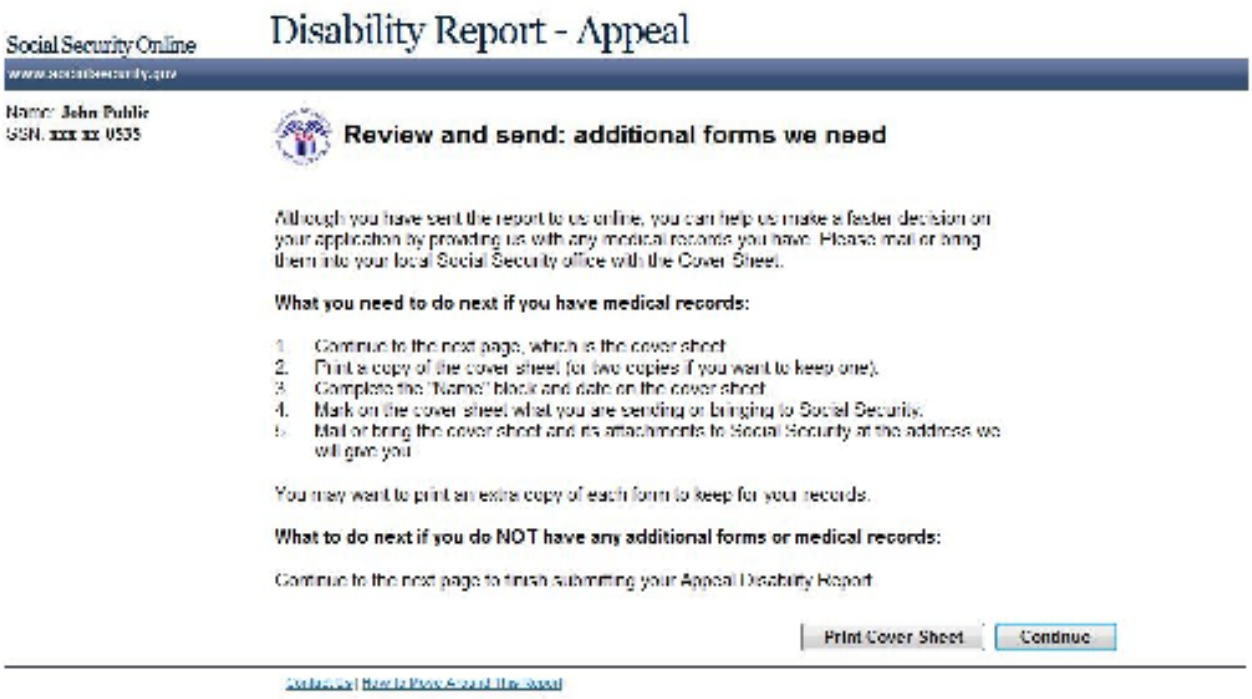
Review and send: Medical Release Form page *(New screen)*



YES path

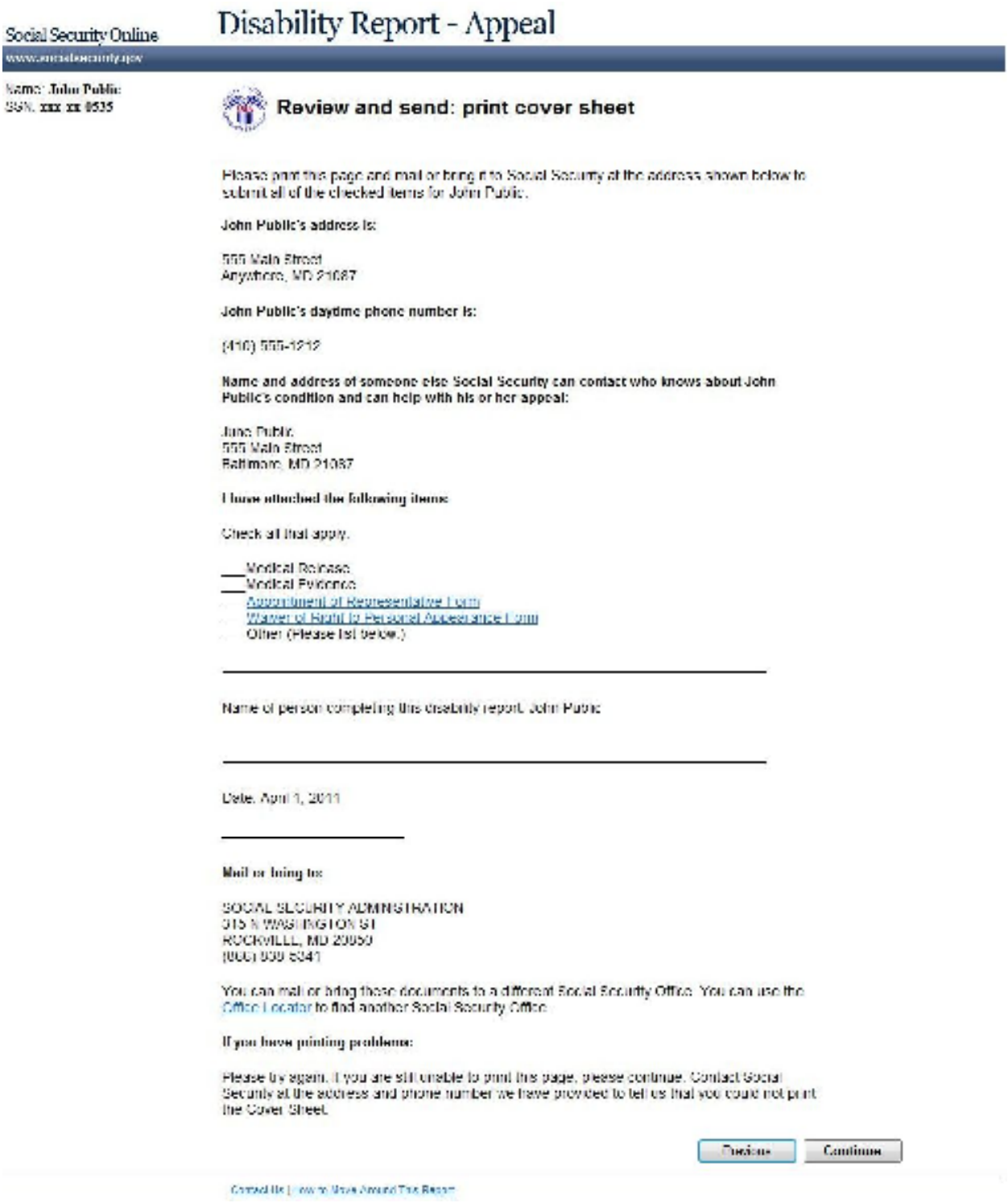
Review and send: additional forms we need page *(New screen for eAuthorization users)*

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



YES path

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



Social Security Online

Disability Report - Appeal

www.socialsecurity.gov

Name: John Public
SSN: xxx xx 0535

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
Anywhere, 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:

Jane 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) 000-0341

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:

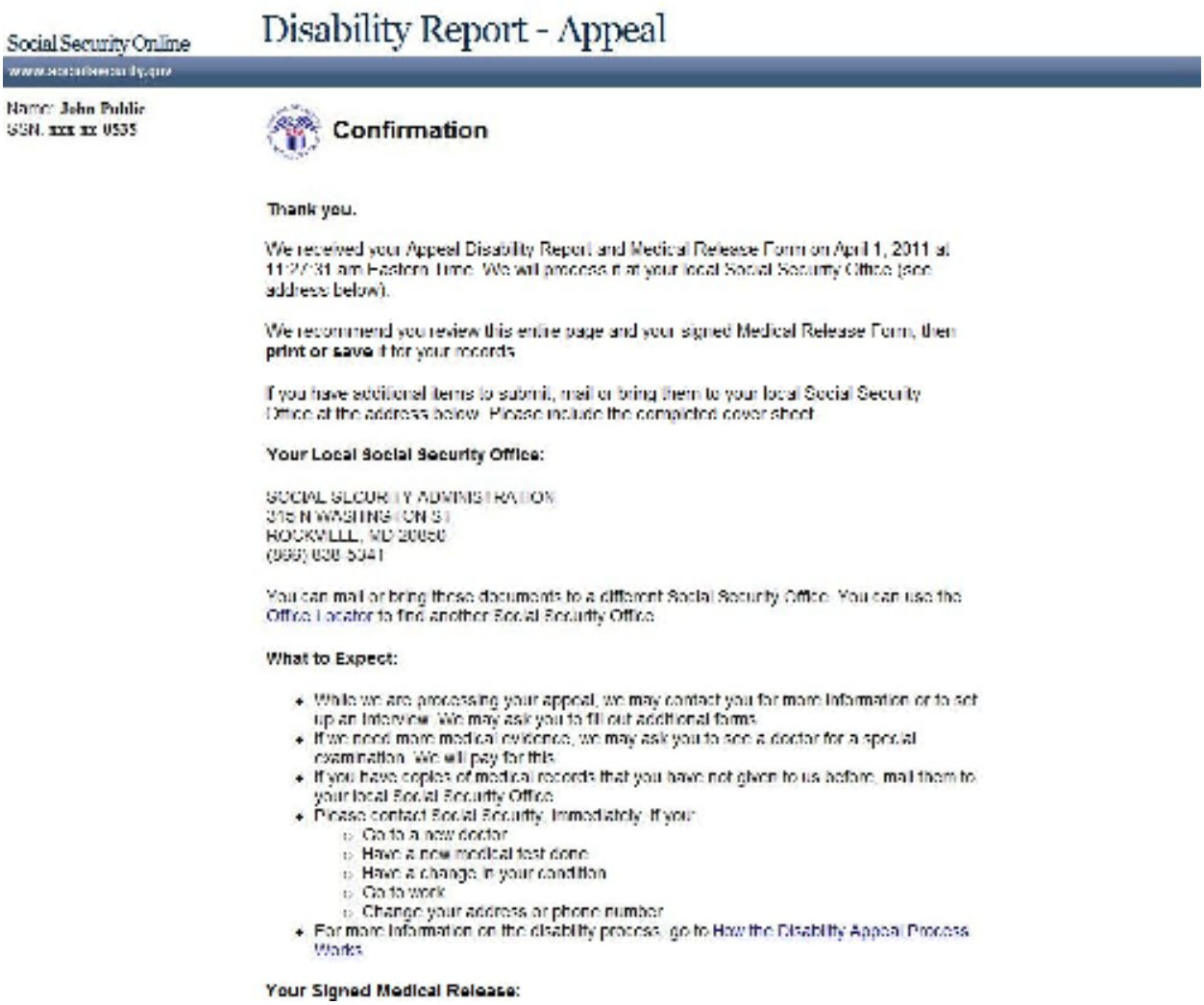
Please try again. If you are still unable to print this page, please continue. Contact Social Security at the address and phone number we have provided to tell us that you could not print the Cover Sheet.

Previous Continue

Contact Us | How to Work 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
(866) 835-5041

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*	Form Approved OMB No. 0960-0623
NAME: (First, Middle, Last) Kelly G Anderson	
SSN 988-77-1234	Birthday (mm/dd/yy) 02/19/68

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):

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
   - Cancer-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)

THIS BOX TO BE COMPLETED BY SSA/DDS [as needed] Additional information to clarify the subject (e.g., other 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 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 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

INDIVIDUAL authorizing disclosure

SIGN ▶ Kelly G Anderson

If not signed by subject of disclosure, specify basis for authority to sign

☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)

If you sign for personal representative, sign here ▶

(see if two signatures required by State law)

Date Signed	Street Address		
06/06/2011 10:27 am	410 Cathedral Street, Apt 10		
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)

SIGN ▶

Phone Number (or Address)	Phone Number (or Address)

This general and specific 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;
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 assure 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

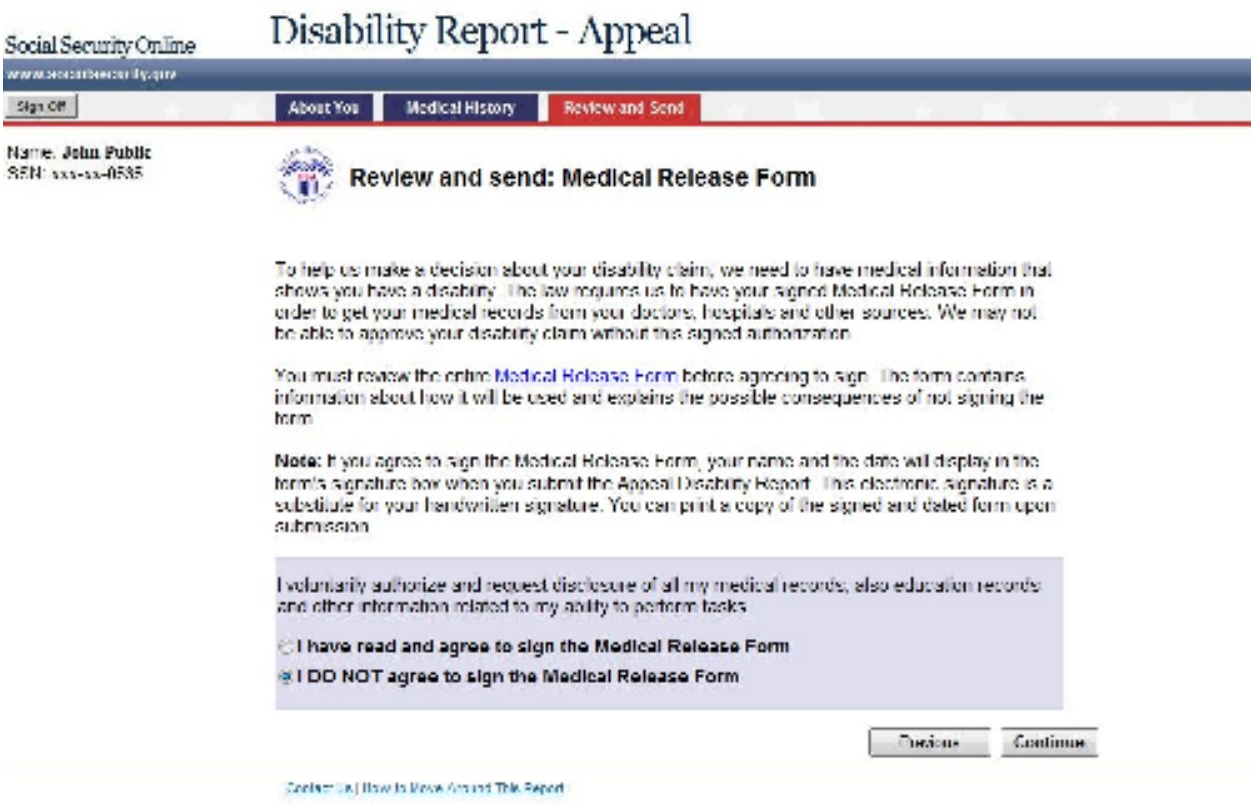
This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to 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 1-800-325-0778). 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.

Previous Finished

Contact Us | How to Move Around This Report

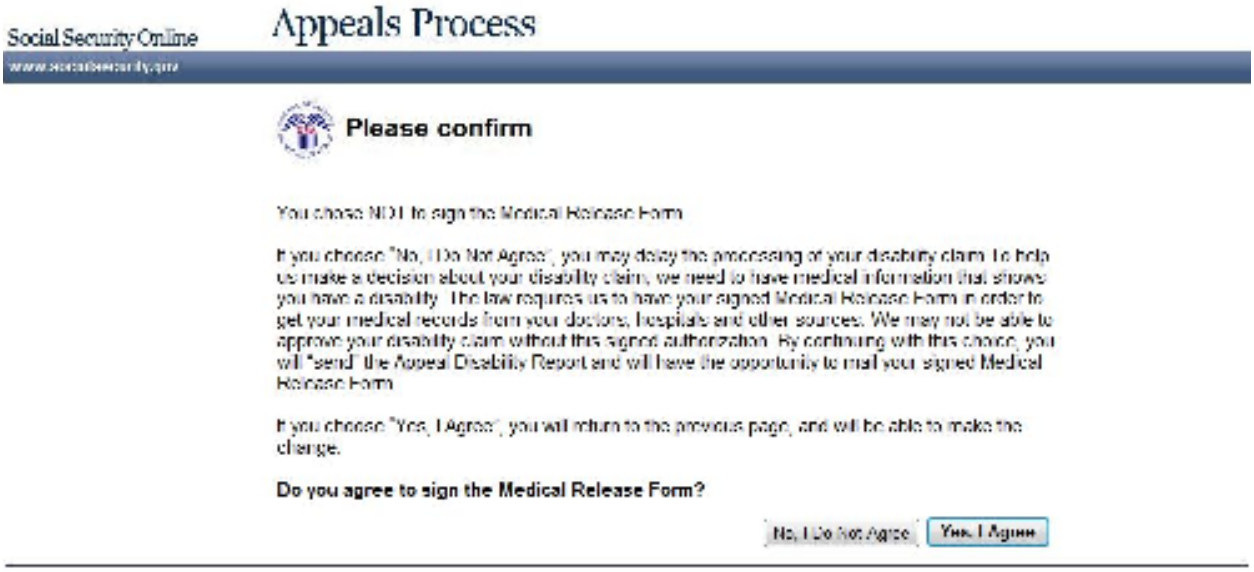
NO then YES path

Review and send: Medical Release Form page

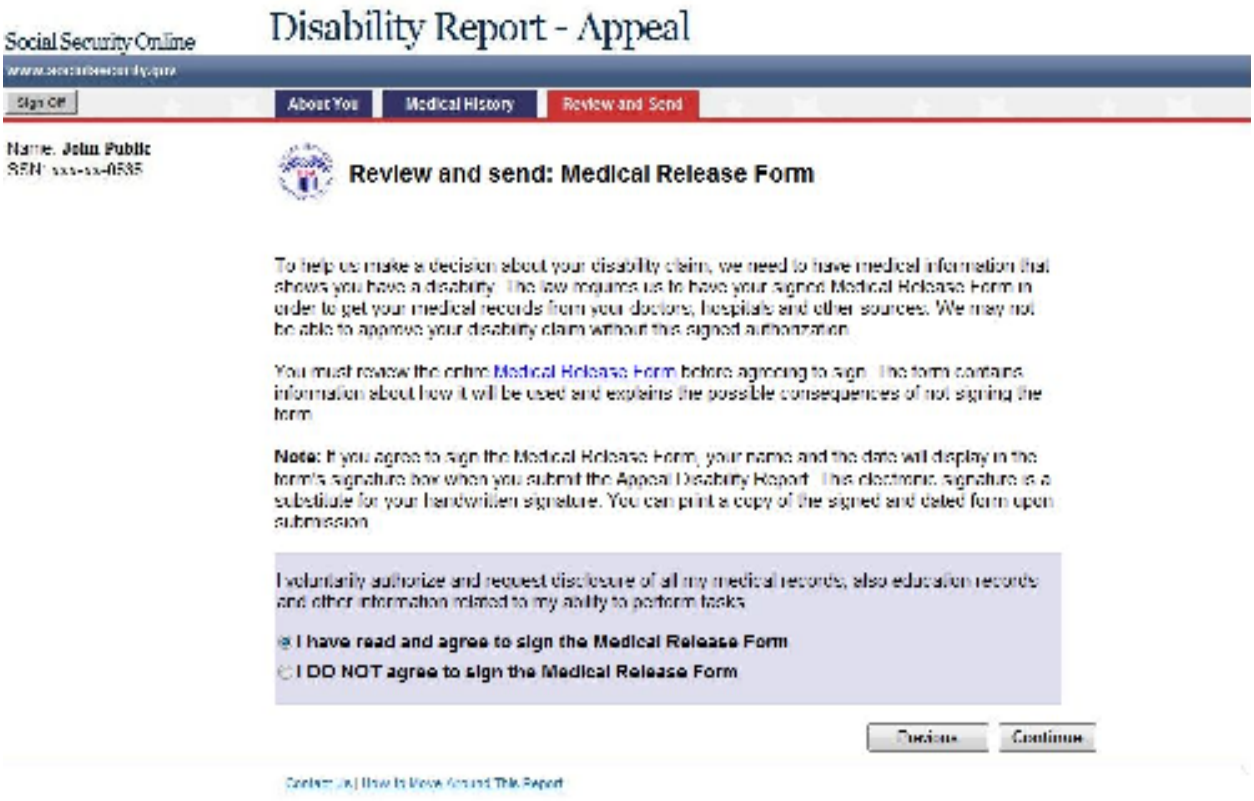


NO then YES path

Please confirm page *(New screen)*



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



Then follows YES path described above.

No Path will continue to have the existing screen flow.

Medical Release Form – opens in new window

Social Security Online
www.socialsecurity.gov

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 164.501)
- 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)

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).

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- 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.

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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 these 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 contacted any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

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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 release 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.

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Form **SSA-827** (1-2009) ef (04-2009) Use 2-2003 and Later Editions Until Supply is Exhausted