i3368 screenshots

Medical Release Page

Yes path


Social Security Online
www.socialsecurity.gov
Adult Disability Report
Kelly G. Anderson xxx-xx-1234
Overview
Identification
Medical
Work/Education
Remarks
Review
Submit
Conditions
Doctors
Hospitals/Clinics
Tests
Medicines
Other Records
Medical Release
<<Previous
Next>>
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 (Authorization to Disclose Information to the Social Security Administration) 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 the 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.
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
Your authorization will not be effective until you review and submit the entire Adult Disability Report. Your name and the date will display in the form's signature box. This electronic signature is a substitute for your handwritten signature. You can print a copy of the signed and dated form upon submission.
Sign Off (finish later)
<<Previous
Next>>

No Path


Social Security Online
www.socialsecurity.gov
Adult Disability Report
Overview
Identification
Medical
Work/Education
Remarks
Review
Submit
Conditions
Doctors
Hospitals/Clinics
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<<|Previous
|Next>>
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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
If you do not agree to sign the form, the processing of your disability claim may be delayed. We may not be able to approve your claim without your signed authorization.
|Sign Off/finish later|
<<|Previous
|Next>>

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)

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. 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 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 1-800-325-0778).** 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) Use 2-2003 and Later Editions Until Supply is Exhausted

Review


Social Security Online
Adult Disability Report
Overview
Identification
Medical
Work/Education
Remarks
Review
Submit
Review
<< [P]revious
[N]ext >>
Review
This is an opportunity to review the answers you have provided thus far. You will be given an opportunity to print your information after you submit your report.
If any sections are not complete, please see if you have the information to complete them. If not, go ahead and send the report in as it is and we'll help you with the rest.
Note: You will have to complete information for the fields marked with
Skip down to:
Identification
Medical
Work/Education
Remarks
Identification
Applicant Name: Kelly G. Anderson
Social Security Number: 988-77-1234
Date of birth: February 19, 1961
Report Completer
Edit
I am completing this disability report for myself
Applicant's Personal Information
Edit
Other Names Used on Medical or Educational Records: No
Preferred Language: English
Mailing Address: 410 Cathedral Street, Apt 7A, Baltimore, MD 21201
Daytime Phone: 410-644-3211

Alternate Phone: 443-799-6692

Reentry Number

Reentry Number#: **D94217143**

Other Contact

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

Conditions

Edit

List of physical and mental conditions:
1: type 2 diabetes
2: heart disease
3: COPD
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 and 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

Medicines

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
Reason: for depression
Prescribed by: Dr. Elijah Saunders

Edit
Medicine #4: Tylenol
Reason: for pain
Prescribed by: Dr. Elijah Saunders

Add Medicine

Other Medical Records

Edit
No Other Medical Records listed

Add Medical Record

Medical Release

Edit
I have read and agree to sign the Medical Release Form

Back to Top

Work/Education

Introduction

Edit
Currently working? No, I have never worked

Work Activity

Edit
Date became unable to work: 03/04/2011

Job History

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

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Remarks

Remarks

Edit
None

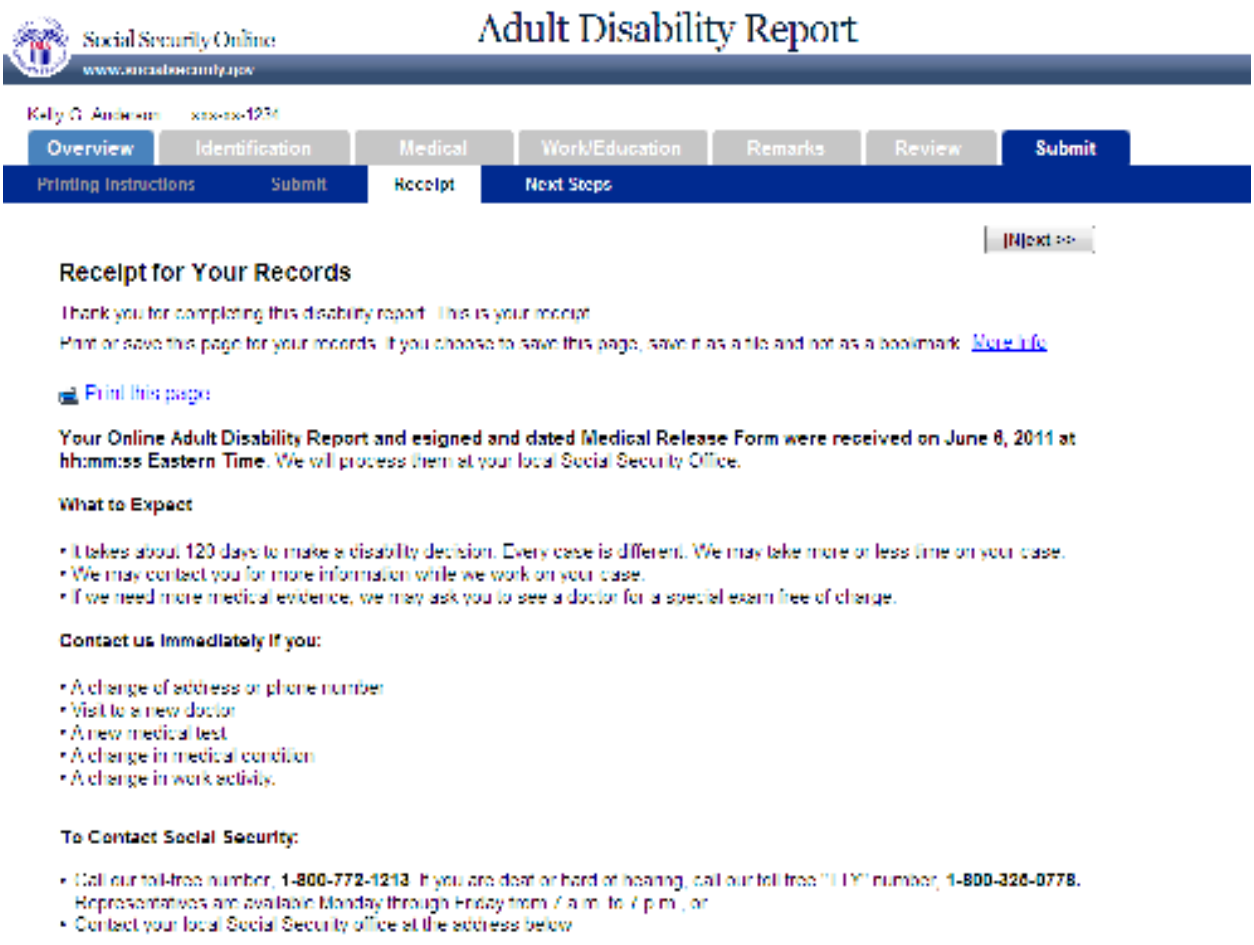
Back to Top

[S]ign Off (finish later) << [P]revious [N]ext >>

Submit


Social Security Online
www.socialsecurity.gov
Adult Disability Report
Kelly G. Anderson
Overview
Identification
Medical
Work/Education
Remarks
Review
Submit
Printing Instructions
Submit
Receipt
Next Steps
[R]eturn to review
<< [P]revious
Submit
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.
I understand and agree that my Medical Release Form will be signed by selecting "Submit" below. I declare under penalty of perjury that I have read and examined all the information and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false statement, or causes someone else 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]revious
Submit

Receipt


Social Security Online
Adult Disability Report
Overview
Identification
Medical
Work/Education
Remarks
Review
Submit
Printing Instructions
Submit
Receipt
Next Steps
Next >>
Receipt for Your Records
Print this page
Your Online Adult Disability Report and esigned and dated Medical Release Form were received on June 6, 2011 at hh:mm:ss 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 toll-free number, 1-800-772-1213. If you are deaf or hard of hearing, call our toll-free "TTY" number, 1-800-325-0778.
• 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

Back to Top

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

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Last visit: 03/2011
Next scheduled appointment: None

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Phone: 410-328-4266
Reason for visits: depression, pain management
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First visit: 11/2008
Last visit: 06/2011
Next scheduled appointment: 08/2011

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Hospital/Clinic #1: Union Memorial Hospital
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Phone: 410-554-2532
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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

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Medicine #3: Cymbalta Reason: for depression Prescribed by: Dr. Elijah Saunders
Medicine #4: Tylenol Reason: for pain Prescribed by: Dr. Elijah Saunders
Other Medical Records
No Other Medical Records listed
Medical Release
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. 0960-0523

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):

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

THIS BOX TO BE COMPLETED BY **SSA/DDS** (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

- 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.

☐ 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)

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
06/06/2011 10:27 am	400 Cathedral Street, Apt 7A		
Phone Number (with area code)	**City**	**State**	**ZIP**
(410)-644-3211	Baltimore	MD	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 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;
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 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 1-800-325-0778).** 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.

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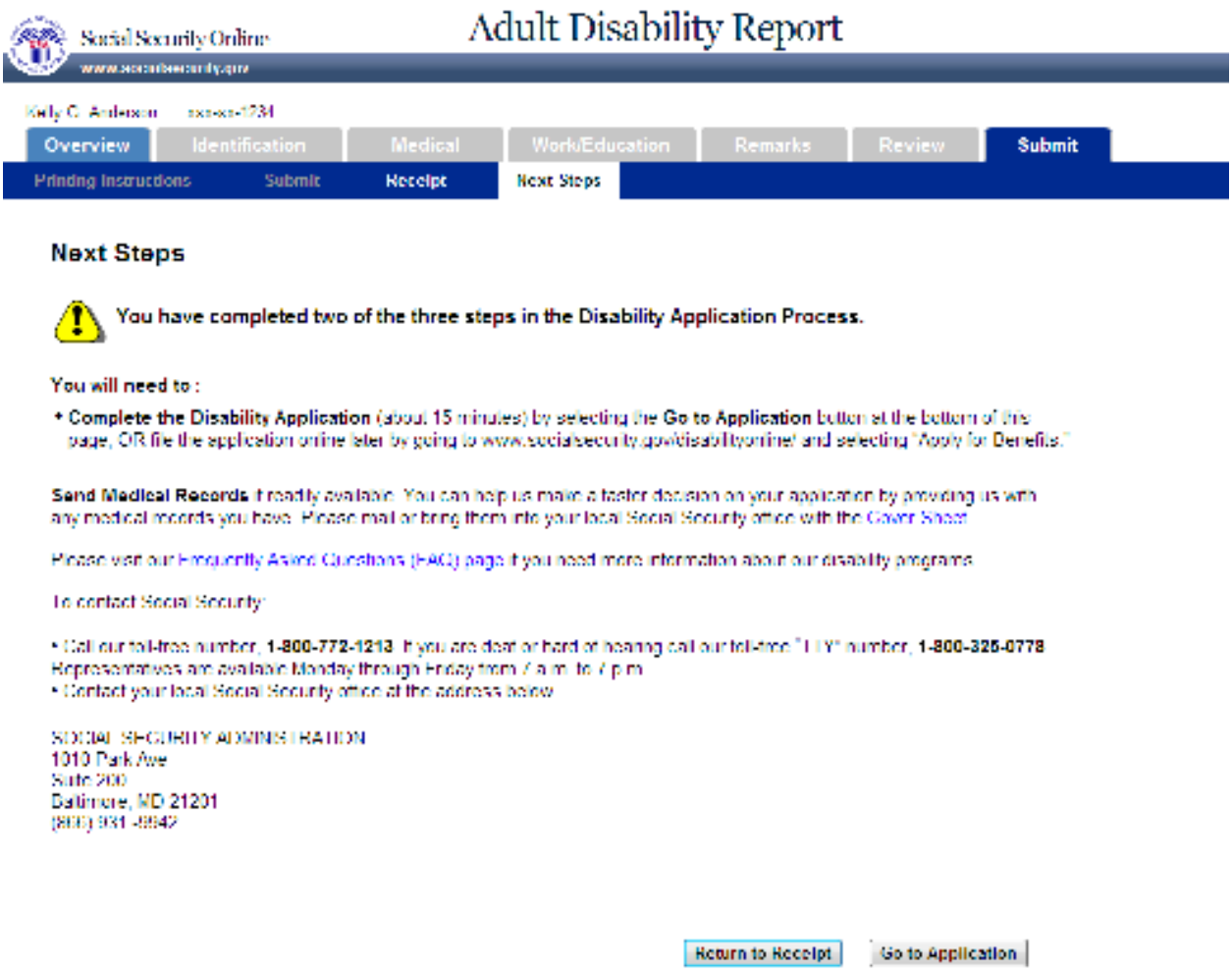

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