



## SOCIAL SECURITY ADMINISTRATION

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Refer To:  
[Claimant SSN]  
[Claimant Name]

Office of Disability Adjudication and Review  
Hearing Office  
Hearing Office Address  
City, State Zip Code  
Telephone Number/ Fax Number

Date

Administrative or Records Office  
Facility Name  
Facility Address  
City, State Zip Code

The above-named individual has appealed a disability case to our office. We are asking you to provide information about the individual that will help us make a decision.

Please ask the person(s) who is most familiar with the individual's records to complete the enclosed form. Please also provide copies of any records that you have not yet provided to us that may help us evaluate the individual's functioning.

We have enclosed a completed SSA-827 signed by the individual or the person acting on his or her behalf, which authorizes you to provide the information and records we are requesting. For your convenience, we have enclosed a return envelope. Alternatively, you may use the enclosed barcode to fax the completed form and record copies to [FECS Toll Free number]. If you have any questions, please contact us at [Hearing Office telephone number].

Sincerely yours,

Hearing Office Employee Name  
Hearing Office Employee Title

Enclosures:  
(SSA-5666, Request for Administrative Information)  
(SSA-827, Authorization To Disclose Information to the Social Security Administration)