Form Approved
OMB No. 0960-0066

AUTHORIZATION TO THE SOCIAL SECURITY ADMINISTRATION TO OBTAIN PERSONAL INFORMATION

APPLICANT'S NAME:

SOCIAL SECURITY NUMBER: XXX-XX-

STREET ADDRESS:

CITY:	STATE:	ZIP CODE:

I authorize the Individual, Organization, or Agency listed below to disclose to the Social Security Administration information about me. I understand that this information will be kept confidential as required by the Social Security Act and the Privacy Act of 1974. This authorization shall remain in effect for no longer than 12 months from the date of my signature.

NAME OF INDIVIDUAL, ORGANIZATION, OR AGENCY:

ADDRESS:

CITY:	STATE:	ZIP CODE:

Signature of Applicant (First name, middle initial, last name) (Write in ink)	Date (Month,day,year)

Signature of Representative Payee or Guardian (First name, middle initial, last name) (Write in ink)	Date (Month,day,year)

Witnesses are required ONLY if this authorization has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses.

Signature of Witness (Write in ink)	(First name, middle initial, last name)	Date (Month, day, year)
ADDRESS		
Signature of Witness (Write in ink)	(First name, middle initial, last name)	Date (Month, day, year)
ADDRESS		

Privacy Act Statement

Collection and Use of Personal Information

Section 205 of the Social Security Act, as amended, authorizes us to collect this information. We will use the information you provide on this form to obtain information from another individual, organization, or agency regarding your Social Security benefits.

Completion of this form is voluntary; however, failure to provide all or part of the information could prevent us from correctly reviewing your Social Security benefits.

We rarely use this information you supply for any purpose other than for reviewing your claim for Social Security benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems is available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - 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 5 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*