Social Security Administration

Form Approved
OMB No. 0960-0189

AUTHORIZATION TO THE SOCIAL SECURITY ADMINISTRATION TO OBTAIN PERSONAL INFORMATION

BENEFICIARY'S NAME:

SOCIAL SECURITY NUMBER:

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 relating to a claim for Social Security benefits. 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 Beneficiary (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 (First name, middle initial, last name) (Write in ink)	Date (Month, day, year)
ADDRESS	

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

Privacy Act Statement

Collection and Use of Personal Information

Section 205(a) of the Social Security Act, as amended, allows us to collect this information. We will use the information you provide to confirm your entitlement to Social Security benefits.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent us from correctly reviewing your Social Security benefits.

We rarely use the information you supply for any purpose other than what we state above, however, we may use the information for the administration of our programs including sharing information:

See Revised Privacy Act Statement Attached

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

2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices 60-0040, entitled Quality Review System, 60-0042, entitled Quality Review Case Files, and 60-0057, entitled Quality Evaluation Data Records. Additional information about these and other system of records notices and our programs is available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

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.*