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, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from verifying the accuracy of your Social Security records.

We will use the information to request and obtain evidentiary documents to verify the accuracy of your Social Security records. We may also share your information for the following purposes, called routine uses:

- To members of the community and local, State, and Federal agencies in order to establish the validity of evidence or to verify the accuracy of information presented by the applicant/ beneficiary, representative payee, legal guardian, or other representative of the applicant/ beneficiary; and

- To a congressional office in response to an inquiry from that office made at the request of the subject of a record.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0040, entitled Quality Review System, as published in the Federal Register (FR) on October 13, 1982, at 47 FR 45606, and 60-0042, entitled Quality Review Case Files, as published in the FR on October 13, 1982, at 47 FR 45607. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

See Revised PRA Statement Attached

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.*