Consent for Disclosure of Records Protected Under the Privacy Act

Instructions for Using this Form

Provide the required information if you are providing **consent and authorizing the agency to disclose your records to another person or entity**. We may charge a fee if you are requesting the information for a purpose unrelated to the administration of a program under the Social Security Act.

NOTE: **Do NOT use this form to:**

- **Request access to information or records about yourself.**
- **Consent to the Social Security Administration releasing a minor child's records to a third party.**
- **Consent to the Social Security Administration releasing a legally incompetent adult's records to a third party.**
- **Request information about your earnings.**
- **Consent to the Social Security Administration releasing information about your earnings to a third party.**

If you are seeking earnings records, complete and submit form SSA-7050-F4, Request for Social Security Earning Information. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/forms/ssa-7050.pdf.

How to Complete this Form

All required fields marked with an asterisk (*) **must** be completed. We will **not** be able to process your request unless you have completed all required fields.

- Your name, date of birth, Social Security number, and address will auto-populate from our records.
- Select the type(s) of information you want us to release, including specific date ranges and benefit type, where applicable.
- Fill in the name, address, and telephone number of the person or entity where you want us to send the requested information.
- Specify the reason you want us to release the information (e.g., SSA claim or benefit application, appeal, or hearing; non-SSA private or personal litigation; non-SSA benefit eligibility for government or private programs; or personal use).
- Sign and date this form.

NOTE: This consent form is valid for one-time use only. A consent form for the release of non-medical records is valid for one year from the date of the electronic signature. A consent form for the release of medical records is valid for 90 days from the date of the electronic signature.

If you do not want to submit your request electronically, you may use the paper Form SSA-3288 to submit your request. Please send or bring the completed Form SSA-3288 to your local servicing office. To locate the appropriate servicing office, visit https://secure.ssa.gov/ICON/main.jsp, and input your ZIP code.

Complete all fields before you electronically sign the form. You may not alter the form after you have signed it.

Privacy Act Statement
Collection and Use of Personal Information

The Privacy Act (5 U.S.C. § 552a) and Section 205(a) of the Social Security Act allow us to collect your information, which we will use to process your authorization for the Social Security Administration (SSA) to release your records. Providing your information is voluntary, but not providing all or part of the information may prevent us from honoring your authorization to release your records.

We may share your information in accordance with the Privacy Act and other Federal laws, including to contractors, other Federal agencies, and others, as necessary, as listed in routine uses in System of Records Notices (SORN) 60-0089, entitled Claims Folders System; 60-0090, entitled Master Beneficiary Record; 60-0320, entitled Electronic Disability Claim File; and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits.

Your information may also be used in computer matching programs to establish or verify eligibility for Federal benefit programs and recouping debts under these programs. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

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 10 to 15 minutes to read the instructions, gather the facts, and answer the questions. 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.***

Consent for Disclosure of Records Protected Under the Privacy Act

You **must** complete all required fields. We will not be able to process your request unless all required fields are completed. *(*Signifies a required field.)*

Information Required for Identity-Proofing and Authentication

This information is required for the agency to verify your identity.

*Your First Name	*Your Last Name
*Your Date of Birth (MM/DD/YYYY)	*Your Full Social Security Number

*Your Address (Number and Street)		Apartment/Suite Number
City	State	ZIP Code

Description of Requested Records

I authorize the Social Security Administration to release the following information or records about me.

*Check at least one box. If requesting medical records, select either box 7 or 8, but do not check both boxes. We will **not** release or disclose records unless you include date ranges and benefit type, where applicable.

- ☐ 1. Verification of Social Security number
- ☐ 2. Current monthly Social Security benefit amount
- ☐ 3. Current monthly Supplemental Security Income payment amount
- ☐ 4. Social Security benefit amounts from date _____ to date _____
- ☐ 5. Supplemental Security Income payment amounts from date _____ to date _____
- ☐ 6. Medicare entitlement from date _____ to date _____
- ☐ 7. Medical records from my claims folder(s) from date _____ to date _____
- ☐ 8. Complete medical records from my claims folder(s)
- ☐ 9. Application for benefits
  - ☐ Retirement benefit applications from date _____ to date _____
  - ☐ Social Security Disability benefit applications from date _____ to date _____
  - ☐ Supplemental Security Income payment applications from date _____ to date _____
- ☐ 10. Award notice
  - ☐ Retirement benefit award notices from date _____ to date _____
  - ☐ Social Security Disability benefit award notices from date _____ to date _____
  - ☐ Supplemental Security Income payment award notices from date _____ to date _____
- ☐ 11. Denial notice
  - ☐ Retirement benefit denial notices from date _____ to date _____
  - ☐ Social Security Disability benefit denial notices from date _____ to date _____
  - ☐ Supplemental Security Income payment denial notices from date _____ to date _____
- ☐ 12. Appeal requests
  - ☐ Retirement benefit appeal requests from date _____ to date _____
  - ☐ Social Security Disability benefit appeal requests from date _____ to date _____
  - ☐ Supplemental Security Income payment appeal requests from date _____ to date _____

Recipient Information

*I authorize the Social Security Administration to release the information or record(s) about me specified above to the person(s) or organization(s) listed below. (Please provide all requested information about at least one person or organization. If a person or organization does not have a fax number, leave that field blank)

Name:

Address:

Phone Number:	Fax Number:

Name:

Address:

Phone Number:	Fax Number:

Name:

Address:

Phone Number:	Fax Number:

*We may charge a fee to release information for non-program purposes or for duplicate requests made for program purposes. Please select the reason for releasing the information from the list below. If we charge a fee, we will notify you of the amount you owe and will explain how you can pay this fee. I want this information released for the following reason:

- ☐ 1. SSA claim or benefit application, appeal, or hearing
- ☐ 2. Non-SSA private or personal litigation
- ☐ 3. Non-SSA benefit eligibility for government or private programs
- ☐ 4. Personal use

By signing below, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above and consenting to and authorizing the Social Security Administration to disclose my records, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. § 1001 by a fine, imprisonment of not more than five years, or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. § 552a(i)(3) by a fine of not more than $5,000.

***By typing in my name, I understand and agree that my request will be signed electronically. I understand that my electronic signature has the same legal meaning, validity, and effect as my handwritten signature.**

*Electronic Signature:	*Date:

Daytime Telephone Number:

Your phone number is not required for us to process this form. However, please provide this information in case we need to contact you about your request.