

**Consent for Release of Information**

**Sign this form only if you want the Social Security Administration to give information or records about you to**  (service provider).

**TO: Social Security Administration fax**  **Local SSA Office**

Customer’s Name

Date of Birth Social Security Number

SOAR Service Provider: Name of Staff (Please Print) Agency Name

I, the undersigned, authorize SSA to release the following information to the SOAR service provider listed below: the date and status of my most current SSI applications or appeals if any and the date and status of my most current SSDI applications and appeals if any. If I was in receipt of benefits and am now in suspense or terminated status, please provide the effective dates. If my most current application(s) was denied, please advise the date(s) of denial and denial reason. If I have a pending appeal please provide the level of appeal that is pending and the date(s) of my appeal(s). If it is at the hearing level please provide the date the reconsideration was denied.

 **(Service Provider) (Fax #)**

This consent for release of information is in effect from to (not to exceed 1 year)

 (MMDDYY) (MMDDYY)

**I want this information released because I am pursuing entitlement to Social Security disability programs. This consent form is intended to be interpreted as an intent by the undersigned to file for Social Security or Supplemental Security Income benefits.** I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information that I provided on this form and that it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: Date: Relationship:

 **(Below, show signatures, names, and addresses of two people if signed by mark.)**

 **Witness #1** **Witness #2**

 (Print Name) (Print Name)

 (Signature) (Signature)

 (Address) (Address)

 (City, State, and Zip code) (City. State, and Zip code)

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| **THIS SECTION TO BE COMPLETED BY THE SOCIAL SECURITY ADMINISTRATION** |
| **\_\_\_\_ No Record \_\_\_\_ Supplemental Security Income \_\_\_\_ Social Security Disability Income****\_\_\_ Terminated Record Date Terminated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **MMDDYY****\_\_\_ Record in Suspense Effective Date of Suspension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **MMDDYY****\_\_\_Birth record previously verified by SSA (please check if applicable)** |
| **Current Claim Status** |
| \_\_\_\_ **SSI Claim Pending:**Initial Claim Date Filed \_\_\_\_\_\_ Reconsideration Date Filed \_\_\_\_\_\_ Hearing Level Date Filed \_\_\_\_\_\_\_\_\_\_ **SSI Claim Denied:** Initial Claim Date Denied \_\_\_\_\_\_ Reconsideration Date Denied \_\_\_\_\_\_ Hearing Level Date Denied \_\_\_\_\_\_ | \_\_\_\_  **SSDI Claim Pending:** Initial Claim Date Filed \_\_\_\_\_\_ Reconsideration Date Filed \_\_\_\_\_\_ Hearing Level Date Filed \_\_\_\_\_\_\_\_\_\_ **SSDI Claim Denied:** Initial Claim Date Denied \_\_\_\_\_\_ Reconsideration Date Denied \_\_\_\_\_\_ Hearing Level Date Denied \_\_\_\_\_\_ |
| **(Circle One)** |
| **Denial Reason:** Medical Non-Medical Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Denial Reason:** Medical Non-MedicalOther \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Allowance**\_\_\_\_ SSI: Eligibility date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ SSDI: Eligibility date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| SSA Claims Information was provided by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (SSA Liaison)Date of Response: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Protective Filing Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSA Field Office Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |