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 my 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. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision on your claim.

We will use the information to review your claim. We may also share your information for the following purposes, called routine uses:

1. To third party contacts in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manager their affairs or eligibility for or entitlement to benefits under the Social Security program when the data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual; and

2. To applicants, claimants, prospective applicants or claimants, other than the data subject, their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees.

In addition, we may share your information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may used 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 benefits 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 Notice (SORN) 60-0089 entitled Claims Folders Systems. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

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.*