Social Security Administration | Form Approved

Consent for Release of Information

OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(* signifies a required field).*

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

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

***NAMEOF PERSON OR ORGANIZATION**	***ADDRESS OF PERSON OR ORGANIZATION**
CUSTOM DISABILITY SOLUTIONS PO BOX 9461 PORTLAND, ME 04094	ALLSUP, INC. 300 ALLSUP PL BELLEVILLE, IL 62223

***I want this information released because:**
We may charge a fee to release information for non-program purposes.
Custom Disability Solutions requires verification of filing and/or receipt of Social Security benefits. This Consent for Release of Information shall remain in effect for two years from the date it is signed below.

***Please release the following information selected from the list below:**
You must specify the records you are requesting by checking at least one box. We will not honor a request for “any and all records” or “my entire file.” Also, we will not disclose records unless you include the applicable date ranges where requested.

1. _ Social Security Number
2. X Current monthly Social Security benefit amount
3. X Current monthly Supplemental Security Income payment amount
4. X My benefit/payment amounts from date_____________ to date _____________
5. _ My Medicare entitlement from date _______________ to date _____________
6. _ Medical records from my claims folder(s) from date ___________ to date _____________
   If you want SSA to release a minor’s medical records, do not use this form. Instead, contact your local Social Security office.
7. _ Complete medical records from my claims folder(s)
8. X Other record(s) from my file **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)** FACT Query-contains your name, Social Security number, sex, date of birth, address, phone number, direct deposit information, account data, insured status date, payment cycle, primary insurance amount history, benefit data, benefit entitlement date, prisoner data, disability data, hospital insurance date, medical insurance date, medical insurance premiums, third party date, state exchange information, enforcement information, SSI information, overpayment/underpayment information, payment history, appeal information, remittance history.

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** ____ ***Date:** ____________________________________

***Address:** ____

Relationship (if not the subject of the record): ___________________________ ***Daytime Phone:** __________________

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of witness:	2. Signature of witness:
____	____
Address (Number and street, City, State, and Zip Code):	Address (Number and street, City, State, and Zip Code):
____	____