DISABILITY REPORT - APPEAL

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

This report is used to update your information for your disability appeal. Completing this report accurately helps us process your claim. Please complete as much of this report as you can.

IF YOU NEED HELP

Please do **not** ask your health care provider to complete this report. You can get help from other people, such as a friend or family member. If you cannot complete this report, a Social Security representative can assist you. If you make an appointment with us, please complete as much of this report as you can and have it with you for your appointment.

HOW TO COMPLETE THIS REPORT

If you have Internet access, you may be able to complete this report online at www.ssa.gov/disability/appeal.

If you complete this report on paper:

- Print or write clearly.
- Include a ZIP or postal code with each address.
- Provide complete phone numbers, including area code. If a phone number is outside the United States, also provide International Direct Dialing (IDD) code and country code.
- If you cannot remember the names and addresses of your health care providers, you may be able to get that information from the telephone book, Internet, medical bills, prescriptions, or prescription medicine containers.
- **ANSWER EVERY QUESTION**, unless the report indicates otherwise. You can write "don't know," or "none," or "does not apply" if you need to.
- If you need more space to answer any question, please use the **REMARKS** section on the last page, SECTION 10. Include the number of the question you are answering.

YOUR MEDICAL RECORDS

If you have any medical records that you have not given to us, send or bring them to our office with this completed report. Please tell us if you want us to return them to you. If you are having an interview in our office, bring your medical records, your prescription medicine containers (if available), and this completed report with you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will request your records. The information that you give us on this report tells us where to request your medical and other records.

HOW TO SUBMIT THIS REPORT

Send or bring this completed report to your local Social Security office. If you have Internet access, you can locate your nearest Social Security office by ZIP code at www.socialsecurity.gov/locator. Our offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), 1614(a), and 1631 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed.

We will use the information to reconsider and review an initial disability determination; review a continuing disability; and evaluate a request for a hearing. We may also share your information for the following purposes, called routine uses:

- 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 payees, for the purpose of assisting the Social Security Administration in administering its 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; and

- To Federal, State, or local agencies (or agents on their behalf) for administering cash or non-cash income maintenance or health maintenance programs (including programs under the Act).

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) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784, and 60-0320, entitled Electronic Disability Claim File,as published in the FR on December 22, 2003, at 68 FR 71210. 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 (OMB) control number. We estimate that it will take about 50 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

AFTER COMPLETING THIS REPORT, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS.

DISABILITY REPORT - APPEAL

For SSA Use Only - Do not write in this box.

Related SSN | Number Holder

If you are filling out this report for someone else, please provide information about him or her. When a question refers to "you", "your," it refers to the person who is applying for disability benefits.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

1.A. Name (First, Middle, Last, Suffix)	**1.B.** Social Security Number

1.C. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

☐ Check this box if you do not have a phone number where we can leave a message

1.D. Alternate Phone Number, another number where we may reach you, if any

1.E. Email address (Optional)

SECTION 2 - CONTACTS

Give the name of someone (**other than your doctors**) we can contact who knows about your medical conditions, and can help you with your claim (e.g., friend or relative)

2.A. Name (First, Middle, Last)	**2.B.** Relationship to Disabled Person

2.C. Mailing Address (Street or PO Box), include apartment number or unit if applicable

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

2.D. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

2.E. Can this person speak and understand English? ☐ Yes ☐ No

If no, what language does the contact person prefer?

2.F. Who is completing this form?

☐ The person who is applying for disability. (**Go to Section 3 - MEDICAL CONDITIONS**)

☐ The person listed in 2.A. (**Go to Section 3 - MEDICAL CONDITIONS**)

☐ Someone else (Please complete the information below)

2.G. Name (First, Middle, Last)	**2.H.** Relationship to Disabled Person

2.I. Mailing Address (Street or PO Box), include apartment number or unit if applicable

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

2.J. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

SECTION 3 - MEDICAL CONDITIONS

3.A. Since you last told us about your medical conditions, has there been any **CHANGE** (for better or worse) in your previously described physical or mental conditions?

☐ Yes, approximate date change occurred: _____ ☐ No

If yes, please describe in detail:

3.B. Since you last told us about your medical conditions, do you have any **NEW** physical or mental conditions?

☐ Yes, approximate date of new conditions: _____ ☐ No

If yes, please describe in detail:

If you need more space, use SECTION 10 - Remarks on the last page

SECTION 4 - MEDICAL TREATMENT

4.A. Have you used any other names on your medical or educational records? Examples are maiden name, other married name, or nickname.

☐ Yes ☐ No

If yes, please list the other names used:

4.B. Since you last told us about your medical treatment, have you seen a doctor or other health care provider, received treatment at a hospital or clinic, or **do you have a future appointment scheduled**?

☐ Yes ☐ No (Go to SECTION 6 - MEDICINES)

4.C. What type(s) of condition(s) were you treated for, or will you be seen for?

☐ Physical ☐ Mental (including emotional or learning problems)

If you answered "Yes" to 4.B., please tell us who may have **NEW** medical records about any of your physical or mental conditions (including emotional or learning problems).

Use the following pages to provide information for up to three (3) providers. **Complete one page for each provider**. If you have more than three providers, list them in SECTION 10 - REMARKS on the last page.

Please include

- doctors' offices
- hospitals (including emergency room visits)
- clinics
- mental health center
- other health care facilities

Only list the providers you have seen since you last told us about your medical treatment.

SECTION 4 - MEDICAL TREATMENT (Continued)

Provider 1

4.D. Name of facility or office	Name of health care provider who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE

Phone Number	Patient ID# (if known)

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic, or Outpatient visits at this facility	**Emergency Room Visits at this facility**	**Overnight Hospital Stays at this facility**	
First visit	Date	Date in	Date out
Last visit	Date	Date in	Date out
Next scheduled appointment (if any)	Date	Date in	Date out
	☐ None	☐ None	

What new or updated medical conditions were treated or evaluated?

What new or updated treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☐ Yes (Please complete the information below.) ☐ No (Go to the next page.)

KIND OF TEST	**DATES OF TEST(S)**	**KIND OF TEST**	**DATES OF TEST(S)**
☐ Biopsy (list body part)		☐ MRI/CT Scan (list body part)	
☐ Blood Test (not HIV)		☐ Speech/Language Test	
☐ Breathing test		☐ Treadmill (exercise test)	
☐ Cardiac Catheterization		☐ Vision Test	
☐ EEG (brain wave test)		☐ X-Ray (list body part)	
☐ EKG (heart test)			
☐ Hearing test		☐ Other (please describe)	
☐ HIV Test			
☐ IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you do not have any more providers to describe, go to SECTION 5 - OTHER MEDICAL INFORMATION on page 8.

SECTION 4 - MEDICAL TREATMENT (Continued)
Provider 2

4.D. Name of facility or office	Name of health care provider who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE

Phone Number	Patient ID# (if known)

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic, or Outpatient visits at this facility	**Emergency Room Visits at this facility**	**Overnight Hospital Stays at this facility**	
First visit	Date	Date in	Date out
Last visit	Date	Date in	Date out
Next scheduled appointment (if any)	Date	Date in	Date out
	☐ None	☐ None	

What new or updated medical conditions were treated or evaluated?

What new or updated treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☐ Yes (Please complete the information below.) ☐ No (Go to the next page.)

KIND OF TEST	**DATES OF TEST(S)**	**KIND OF TEST**	**DATES OF TEST(S)**
☐ Biopsy (list body part)		☐ MRI/CT Scan (list body part)	
☐ Blood Test (not HIV)		☐ Speech/Language Test	
☐ Breathing test		☐ Treadmill (exercise test)	
☐ Cardiac Catheterization		☐ Vision Test	
☐ EEG (brain wave test)		☐ X-Ray (list body part)	
☐ EKG (heart test)			
☐ Hearing test		☐ Other (please describe)	
☐ HIV Test			
☐ IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you do not have any more providers to describe, go to SECTION 5 - OTHER MEDICAL INFORMATION on page 8.

SECTION 4 - MEDICAL TREATMENT (Continued)
Provider 3

4.D. Name of facility or office	Name of health care provider who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE

Phone Number	Patient ID# (if known)

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic, or Outpatient visits at this facility	**Emergency Room Visits at this facility**	**Overnight Hospital Stays at this facility**	
First visit	Date	Date in	Date out
Last visit	Date	Date in	Date out
Next scheduled appointment (if any)	Date	Date in	Date out
	☐ None	☐ None	

What new or updated medical conditions were treated or evaluated?

What new or updated treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☐ Yes (Please complete the information below.) ☐ No (Go to the next page.)

KIND OF TEST	**DATES OF TEST(S)**	**KIND OF TEST**	**DATES OF TEST(S)**
☐ Biopsy (list body part)		☐ MRI/CT Scan (list body part)	
☐ Blood Test (not HIV)		☐ Speech/Language Test	
☐ Breathing test		☐ Treadmill (exercise test)	
☐ Cardiac Catheterization		☐ Vision Test	
☐ EEG (brain wave test)		☐ X-Ray (list body part)	
☐ EKG (heart test)			
☐ Hearing test		☐ Other (please describe)	
☐ HIV Test			
☐ IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you have been treated by more providers, use SECTION 10 - REMARKS on the last page.

SECTION 5 - OTHER MEDICAL INFORMATION

5. Since you last told us about your other medical information, does anyone else have medical information about any of your **physical or mental** conditions (including emotional and learning problems) or are you scheduled to see anyone else?

This may include:
- workers' compensation
- vocational rehabilitation services
- insurance companies who have paid you disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

☐ YES (Please complete the information below.)

☐ NO (Go to SECTION 6 - MEDICINES.)

Name of Organization	Claim or ID Number (if any)

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

Name of Contact Person	Phone Number

Date of First Contact	Date of Last Contact	Date of Next Contact (if any)

Reasons for Contacts

If you need to list more people or organizations, use SECTION 10 - REMARKS on the last page.

SECTION 6 - MEDICINES

6. Are you currently taking any medicines (prescription or non-prescription)?

☐ YES (Please complete the information below. You may need to look at your medicine containers.)

☐ NO (Go to SECTION 7 - ACTIVITIES.)

NAME OF MEDICINE	IF PRESCRIBED, NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need to list more medicines, use SECTION 10 - REMARKS on the last page.

SECTION 7 - ACTIVITIES

7. Since you last told us about your activities, has there been any **change** (for better or worse) in your previously described daily activities due to your physical or mental conditions? (Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.)

☐ Yes ☐ No

If yes, please describe in detail:

If you need more space, use SECTION 10 - REMARKS on the last page.

SECTION 8 - WORK AND EDUCATION

8.A. Since you last told us about your work, have you worked or has your work changed?

☐ Yes ☐ No

If yes, you will be asked to provide additional information.

8.B. Since you last told us about your education, have you completed or are you enrolled in any type of GED classes, specialized job training, trade school, vocational school or college classes?

☐ Yes ☐ No

If yes, what type?

Date(s) attended:

Degree(s) attained, if any:

Date of attainment (MM/YYYY):

If you need more space, use SECTION 10 - REMARKS on the last page.

SECTION 9 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES

9. Since you last told us about your vocational rehabilitation, have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program?
- an individualized plan for employment with a vocational rehabilitation agency or any other organization?
- a Plan to Achieve Self-Support (PASS)?
- an individualized education program (IEP) through an educational institution (if a student age 18-21)?
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ Yes (Please complete the information below.)

☐ No (Go to SECTION 10 - REMARKS.)

Name of Organization or School

Name of Counselor, Instructor, or Job Coach	Phone Number

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

Date when you started participating in the plan or program:

If you need more space, use SECTION 10 - REMARKS on the last page.

SECTION 10 - REMARKS

Use this space to provide any information you could not show in earlier sections of this form or additional information you feel we should know about. Please be sure to include the number of the question you are answering (For example, 3A, 4D, etc.).

Date Report Completed MM/DD/YYYY:

SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0269

REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

*(Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)*

See Privacy Act Notice

1. Claimant Name	2. Claimant SSN	3. Claim Number, if different

4. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination because:

An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review or the Department of Health and Human Services will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

5. I have additional evidence to submit. ☐ Yes ☐ No

Name and source of additional evidence, if not included.

Submit your evidence to the hearing office within 10 days. Your servicing Social Security office will provide the hearing office's address. Attach an additional sheet if you need more space.

6. Do not complete if the appeal is a Medicare issue. Otherwise, check one of the blocks

☐ I wish to appear at a hearing.

☐ I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)

Representation: You have a right to be represented at the hearing. If you are not represented, your Social Security office will give you a list of legal referral and service organizations. If you are represented, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.

7. CLAIMANT SIGNATURE (OPTIONAL)	DATE	8. NAME OF REPRESENTATIVE (if any)	DATE

RESIDENCE ADDRESS			ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	FAX NUMBER		TELEPHONE NUMBER	FAX NUMBER	

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION- ACKNOWLEDGMENT OF REQUEST FOR HEARING

9. Request received on _____ (Date) by: _____ (Print Name) _____ (Title)

_____ (Address) _____ (Servicing FO Code) _____ (PC Code)

10. Was the request for hearing received within 65 days of the reconsidered determination? ☐ Yes ☐ No

If no, attach claimant's explanation for delay and supporting documents if any.

11. If claimant is not represented, was a list of legal referral service organizations provided? ☐ Yes ☐ No

12. Interpreter needed ☐ Yes ☐ No

Language (including sign language):

13. Check one: ☐ Initial Entitlement Case
☐ Disability Cessation Case or ☐ Other Postentitlement Case

14. HO COPY SENT TO: _____ HO on _____
☐ Claims Folder (CF) Attached: ☐ Title (T) II; ☐ T XVI;
☐ T VIII; ☐ T XVIII; ☐ T II CF held in FO ☐ Electronic Folder
☐ CF requested ☐ T II; ☐ T XVI; ☐ T VIII; ☐ T XVIII
(Copy of email or phone report attached)

16. CF COPY SENT TO: _____ HO on _____
☐ CF Attached: ☐ Title (T) II; ☐ T XVI; ☐ T XVIII
☐ Other Attached: _____

15. Check all claim types that apply:

☐ Retirement and Survivors Insurance Only	(RSI)
☐ Title II Disability - Worker or child only	(DIWC)
☐ Title II Disability - Widow(er) only	(DIWW)
☐ Title XVI (SSI) Aged only	(SSIA)
☐ Title XVI Blind only	(SSIB)
☐ Title XVI Disability only	(SSID)
☐ Title XVI/Title II Concurrent Aged Claim	(SSAC)
☐ Title XVI/Title II Concurrent Blind	(SSBC)
☐ Title XVI/Title II Concurrent Disability	(SSDC)
☐ Title XVIII Hospital/Supplementary Insurance	(HI/SMI)
☐ Title VIII Only Special Veterans Benefits	(SVB)
☐ Title VIII/Title XVI	(SVB/SSI)
☐ Other - Specify:	

PRIVACY ACT STATEMENT
Request for Hearing by Administrative Law Judge

Sections 205(a) (42 U.S.C. 405 (a)), 702 (42 U.S.C. 902), 1631(e) (1) (A), and; (B) (42 U.S.C. 1383(e) (1) (A) and (B)), 1839(i) (42 U.S.C. 1395r), 1869(b) (1), and (c) (42 U.S.C. 1395ff) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to continue processing your claim.

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

We rarely use the information you supply for any purpose other than for determining problems in Social Security programs. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include, but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and

4. To facilitate statistical research, audit, or investigate activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in System of Records Notices 60-0089, Claims Folder System and 60-0050, Completed Determination-Continuing Disablility Determinations. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or any local Social Security office.

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 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *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.***

Whose Records to be Disclosed	
NAME *(First, Middle, Last, Suffix)*	
SSN	Birthday *(MM/DD/YYYY)*

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records: also education records and other information related to my ability to perform tasks. This includes Specific permission to release:***

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed). Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY **INDIVIDUAL authorizing disclosure Signature**	**IF not signed by subject of disclosure, specify basis for authority to sign** ☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)
	(Parent/guardian/personal representative sign here if two signatures required by State law)

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

Signature	**IF** needed, second witness sign here (e.g., if signed with "X" above)
Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827, "Authorization to Disclose Information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631(d) of the Social Security Act, as amended, allow 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 that could result in a denial or loss of benefits.

We will use the information you provide to determine your eligibility or continuing eligibility for benefits, and your ability to manage any benefits that you currently receive.

We may also share your information for the following purposes, called routine uses:

1. To State audit agencies for auditing State supplementation payments and Medicaid eligibility considerations;
2. To third party contacts where necessary to establish or verify information provided by representative payees or payee applicants; and
3. To Federal, State or local agencies for administering cash or non-cash income maintenance or health maintenance programs.

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 (SORNs) 60-0089, entitled Claims Folders Systems; 60-0090, entitled Master Beneficiary Record; 60-0320, entitled Electronic Disability; and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits. 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 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *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.***