

Consent for Release of Information

TO: Social Security Administration

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

I authorize the Social Security Administration to release information or records about me via facsimile or postal correspondence, to:

NAME	ADDRESS
Iowa Workforce Development	600 S Pierce Ave Mason City, IA 50401 Fax: 641-422-1543 Phone: 641-422-1500

I want this information released because:

*I need to have accurate and current information about my benefits to learn how these benefits would be affected by work. This will allow me to make informed decisions about working. Please send me a Benefits Planning Query (BPQY).*

Please release the following information:

- \_\_\_\_\_ Social Security Number
- \_\_\_\_\_ Identifying information (includes date and place of birth, parents' names)
- Monthly Social Security benefit amount
- Monthly Supplemental Security Income payment amount
- \_\_\_\_\_ Information about benefits/payments I received from \_\_\_\_\_ to \_\_\_\_\_
- \_\_\_\_\_ Information about my Medicare claim/coverage from \_\_\_\_\_ to \_\_\_\_\_  
(specify) \_\_\_\_\_
- \_\_\_\_\_ Medical records
- \_\_\_\_\_ Record(s) from my file (specify) \_\_\_\_\_
- Other (specify): See below.

**Cash:** Type of Benefit(s), current payment status, statutory blindness, date of disability onset, date of entitlement, Gross & net amount of benefits, others paid on the record, total family cash benefit, overpayment balance, monthly amount withheld.

**Medical Reviews:** Next medical review, medical re-exam cycle

**Representation:** Representative payee, authorized representative

**Health Insurance:** Type of Medicare (part A, part B, part C/D), start date, stop date, buy-in or subsidy, Medicaid eligibility, start date, stop date, buy-in or subsidy.

**Title XVI (SSI) Work Exclusion:** Blind work expenses, impairment-related work expenses, student earned income exclusions, pass exclusion, SSI earnings.

**Title II (SSDI) Work Exclusion:** Trial work months, start date, end date, number of months used, month of cessation, current SGA level.

**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 on this form and 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: \_\_\_\_\_

(Show signatures, names and addresses of two people if signed by mark.)

Date: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Social Security Administration**  
**Consent for Release of Information**

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Please read these instructions carefully before completing this form.

**When to Use  
This Form**

**Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor, or an insurance company).**

**Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor's:**

- **nonmedical** records, should use this form.
- medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F3. You can get this form at any Social Security office.

**How to  
Complete  
This Form**

This consent form must be completed and signed only by:

- the person to whom the information or record applies, or
- the parent or legal guardian of a minor to whom the **nonmedical** information applies, or
- the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:

- Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
- Fill in the name and address of the individual or group to which we will send the information.
- Fill in the reason you are requesting the information.
- Check the type(s) of information you want us to release.
- Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

**PAPERWORK REDUCTION ACT:** This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 3 minutes to read the instructions, gather the necessary facts, and answer the questions.