Form Approved
OMB No. 0960-0566

Social Security Administration

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 to:

NAME	ADDRESS
	Employment Resources, Inc.
	4126 Lien Road #104
	Madison, WI 53704

I want this information released because:
Benefits Counseling. Please send me a Benefits Planning Query.

(There may be a charge for releasing information.)

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) My Cash Benefits, Health Insurance, Medical Review Dates, Representation, SSDI, and SSI work activity and earnings.
- ✔ Other (specify) All employment supports data on Social Security's records.

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: _____