Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

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

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

***NAME OF PERSON OR ORGANIZATION:**

LIFE INC. EMPLOYMENT SOLUTIONS -
AN APPROVED EMPLOYMENT NETWORK (EN) WITH
SSA'S TICKET TO WORK PROGRAM

***ADDRESS OF PERSON OR ORGANIZATION:**
**** PHONE NUMBER OF PERSON OR ORGANIZATION:**

725 E. KARSCH BLVD. / P.O. BOX 967
FARMINGTON, MO 63640
PH: 573-7556-4314 / FAX: 573-756-3507

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

I'm interested in work and my Ticket to Work Program options. Please verify my current benefits and please FAX the BPQY verification to 573-756-3507 to help expedite the process.

***Please release the following information selected from the list below:**
Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☒ Current monthly Social Security benefit amount
3. ☒ Current monthly Supplemental Security Income payment amount
4. ☐ Social Security benefit amounts from date _____ to date _____
5. ☐ Supplemental Security Income payment amounts from date _____ to date _____
6. ☐ Medicare entitlement from date _____ to date _____
7. ☐ Medical records from date _____ to date _____
8. ☐ Complete medical records
9. ☒ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)

   Please verify my benefits using the BPQY. (BPQY Handbook 3-2021). Please also note the disability on record and verify 1619B status for applicable work incentive counseling.

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 § 1746) 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 or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

****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)