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, phone, email or postal correspondence, to:

NAME	ADDRESS
Organization Name LIFE, INC. Employment Solutions	Organization Address and Contact information PO Box 967, 725 E. Karsch, Farmington, MO 63640 Ph: 573-756-4314 EXT 25 **Please return via FAX 573-756-3507**

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)
__X__ Monthly Social Security benefit amount
__X__ 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) _____
__X__ Other (specify): See below.

Additional Information Requested:
Ticket to Work: If the person has an assigned Ticket, when was it assigned and please include the EN's contact information.
1619b Status: If the person is in non-pay for income do they have 1619b status?
Disability of Record: What is the person's disability of record?

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, IRWE or Subsidy.

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. This authorization is effective until 1 year of the signed date of this form.

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

Date: _____ Relationship: _____