

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
SSDC Services Corp	28125 Cabot Drive, Suite 201, Novi MI 48377
Agents of SSDC Services Corp	28125 Cabot Drive, Suite 201, Novi, MI 48377

I want this information released because :

To assist with the procession of my claim and coordination of benefits
(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) _____
- _____
- Other (specify) _____

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: X

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

Date: _____ Relationship: _____