**Whose Records to be Disclosed**

NAME *(First, Middle, Last, Suffix)*
Poner Nombre

| SSN | Birthday *(MM/DD/YYYY)* |
|---|---|
| Poner Núm. Seguro Social | Poner fecha de Nacimiento |

# AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

**I voluntarily authorize and request disclosure** (including paper, oral, and electronic interchange):

**OF WHAT** ***All my medical records: also education records and other information related to my ability to perform tasks. This includes Specific permission to release:***

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

**FROM WHOM**

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

**THIS BOX TO BE COMPLETED BY SSA/DDS (as needed).** Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

**TO WHOM** **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

**PURPOSE** Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

**EXPIRES WHEN** This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

**PLEASE SIGN USING BLUE OR BLACK INK ONLY**
**INDIVIDUAL authorizing disclosure Signature**

→ Poner firma aquí

**IF not signed by subject of disclosure, specify basis for authority to sign**
☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)

(Parent/guardian/personal representative sign here if two signatures required by State law)

| Date Signed | Street Address | | |
|---|---|---|---|
| Poner fecha | Dirección Postal | | |
| **Phone Number (with area code)** | **City** | **State** | **ZIP** |
| Poner Núm. Teléfono | Poner ciudad | PR | Zip Code |

**WITNESS** *I know the person signing this form or am satisfied of this person's identity:*

| Signature | IF needed, second witness sign here (e.g., if signed with "X" above) |
|---|---|
| No tiene que llenar | nada aquí abajo |
| Phone Number (or Address) | Phone Number (or Address) |

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

AUTHORIZATION FOR THE SOCIAL SECURITY ADMINISTRATION
TO OBTAIN WAGE AND EMPLOYMENT INFORMATION FROM PAYROLL DATA PROVIDERS

| 1. Individual Whose Wage and Employment Information Will Be Obtained | 2. Social Security Number (for Individual) |
|---|---|
| → **Poner su nombre aquí** | → **Núm. Seguro Social** |
| 3. Claimant/Beneficiary (if different from above)<br>**NO llenar nada aquí** | 4. Claimant/Beneficiary Social Security Number (if different from above)<br>**NO llenar nada aquí** |

5. I understand:

- Section 1184 of the Social Security Act (Act) authorizes the Social Security Administration (SSA) to enter into information exchanges with payroll data providers. SSA will use my authorization to obtain wage and employment information from payroll data providers. Section 1184(c)(1) of the Act defines a payroll data provider as payroll providers, wage verification companies, and other entities that collect and maintain data about employment and wages.
- If SSA obtains payroll data provider records about me based on this authorization, it may use the records for purposes other than for the program that the authorization covers. For example, SSA may use my records to decide whether I can get benefits under both the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs, even if this authorization is limited to one program. Additional information about how SSA may use and disclose my records is in the Privacy Act Statement below.
- SSA will request authorization under the SSDI and SSI programs. SSA will request authorization once under each program, even if I have multiple SSDI or SSI claims. However, SSA may use my authorization to obtain payroll data provider records about me for any claims associated with the ones I file, such as a claim for benefits by my spouse or child. If I revoke my authorization, SSA will not use the authorization to obtain my information for any of my claims under both programs.
- By authorizing the SSA to obtain my wage and employment information, I will receive protection from certain penalties, pursuant to section 1129A and section 1631(e)(2) of the Act. I further understand that if I later revoke my authorization, I will no longer get this protection.
- Not all employers report wage and employment information to payroll data providers that SSA uses. If my employer does report, SSA will request my wage and employment information from the payroll data provider. I am still responsible for making sure that my wage and employment information are reported accurately to SSA.
- If we paid you too much in benefits because the payroll data provider reported your wage and employment information inaccurately, you may have to pay us back.
- If my employer does not report or stops reporting to a payroll data provider that SSA uses, I will have to report my wage and employment information.
- I am authorizing payroll data providers (as defined in section 1184 of the Act) to disclose to the SSA data about me or that of the person named above whom I legally represent.

5.a. Answer questions (5.b. and 5.c.) below by checking Yes or No.
Note: If you are filing or receiving benefits under SSDI and SSI, you must answer both questions.

**Marcar aquí con una "x"**

5.b. **Do you give us authorization to obtain your wage and employment information from payroll data providers for the Social Security Disability Insurance (SSDI) program?**
Your authorization will help us determine whether you are entitled to benefits, or continue to be entitled to benefits. Giving us your authorization may also help us avoid paying the wrong amount. We will ask for all of your records held by the payroll data provider whenever we determine that we need these records to make decisions on your entitlement to benefits. Your authorization will remain in effect until:
- We make a final adverse decision on your application for benefits and no other claims or appeals are pending;
- Your entitlement to benefits ends and no other claims or appeals are pending; or
- You revoke your authorization in writing.

SSDI

☒ Yes

☐ No

5.c. **Do you give us authorization to obtain your wage and employment information from payroll data providers for the Supplemental Security Income (SSI) program?**

Your authorization will help us determine whether you or the person who filed an application for benefits, is eligible for SSI, or continues to be eligible for SSI. Giving us your authorization may also help us avoid paying the wrong amount. We will request your records held by the payroll data provider whenever we determine that we need these records to make decisions on your eligibility for SSI. Your authorization will remain effective until:

- We make a final adverse decision on the application for benefits and no other claims or appeals are pending;
- You or the other person's eligibility for payments ends and no other claims or appeals are pending;
- You revoke your authorization in writing; or
- We no longer count your income and resources to the other person.

SSI

☒ Yes

☐ No

**Marcar aquí con una "x"**

6. PLEASE SIGN IN BLACK OR BLUE INK ONLY

| Signature | Date signed |
|---|---|
| **Poner su firma aquí** | **Poner fecha** |

If not signed by the individual whose wage and employment information will be obtained, what is the basis for the authority to sign

☐ Parent of minor **NO llenar nada aquí** ☐ Guardian

Print name of parent/guardian

**NO llenar nada aquí**

Mailing address of individual authorizing disclosure

**Poner Dirección Postal aquí**

| City | State | ZIP Code |
|---|---|---|
| **Poner Ciudad aquí** | **PR** | **Su código postal** |

7. Your authorization does not ordinarily have to be witnessed. However, if you have signed using a mark, two witnesses to the signing who know you must sign below giving their full addresses.

**If needed, WITNESS** *I know the person signing this form or am satisfied of this person's identity:*

Mailing Address for Witness 1

**NO llenar nada aquí**

If needed, second witness sign here (e.g., if signed with a mark above)

**NO llenar nada aquí**

Mailing Address for Witness 2

**NO llenar nada aquí**

# "Internet Application Summary"

## My Responsibilities

I agree to notify Social Security promptly if I (or anyone for whom I receive benefits)

- become employed or self-employed while outside the U.S.,
- change citizenship, or
- go (for 30 days or more) to any country other than the residence address shown on this application.

I agree to return any payments that are not due.

I declare under penalty of perjury that I have examined all the information on this application and it is true and correct to the best of my knowledge.

Signature: Poner firma aquí ______________ Date: Poner fecha aquí ______________

Witnesses are required only if this application has been signed by mark (x) above. If signed by (x), two witnesses to the signing who know the applicant must sign below, giving their full addresses.

No llenar nada aquí abajo

| | |
|---|---|
| Signature of Witness | Signature of Witness |
| Number and Street Address | Number and Street Address |
| City, State and ZIP Code | City, State and ZIP Code |

This form should be submitted to the address shown on your notice.