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
Indianapolis Litigation Support Group	120 East Market Street Suite 607 Indianapolis IN 46204
For:	

I want this information released because:

(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 know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

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

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