

**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).

**TO: Social Security Administration**

**\*My Full Name**

**\*My Date of Birth  
(MM/DD/YYYY)**

**\*My Social Security Number**

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

**\*NAME OF PERSON OR ORGANIZATION:**

NuQuest

**\*ADDRESS OF PERSON OR ORGANIZATION:**

PO Box 915619

Longwood, FL 32791-5619

(P) 866-858-7161 (F) 407-389-0299

**\*I want this information released because:** To determine my eligibility or entitlement for SSDI and Medicare  
We may charge a fee to release information for non-program purposes.

**\*Please release the following information selected from the list below:**

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

- 1.  Social Security Number
- 2.  Current monthly Social Security benefit amount
- 3.  Current monthly Supplemental Security Income payment amount
- 4.  My benefit or payment amounts from date \_\_\_\_\_ to date \_\_\_\_\_
- 5.  My Medicare entitlement from date \_\_\_\_\_ to date \_\_\_\_\_
- 6.  Medical records from my claims folder(s) from date \_\_\_\_\_ to date \_\_\_\_\_

If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.

- 7.  Complete medical records from my claims folder(s)
- 8.  Other record(s) from my file (**you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire**) Verify Social Security entitlement, date of SS entitlement or date of application if pending, date of denial, date of appeal, status of appeal, basis for entitlement (disability or age), name of representative payee if assigned, number of eligible work quarters, if quarters adequate for Social Security benefits, Medicare Status, Medicare number, date of entitlement for Medicare part A and B

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 § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain access to records about another person under false pretenses is punishable by a fine of up to \$5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

**\*Signature:** \_\_\_\_\_

**\*Date:** \_\_\_\_\_

**\*Address:** \_\_\_\_\_



**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)