Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*signifies a required field). **Please complete these fields in case we need to contact you about the consent form).*

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:**

Blackburn Group, Inc.
And its representatives including but not limited to Robert Blackburn and Kathryn Blackburn

***ADDRESS OF PERSON OR ORGANIZATION:**

1173 Pittsford Victor Rd., Suite# 250
Pittsford, NY 14534-3823
585-586-4530

***I want this information released because:** I need it for Medicare Verification purposes.

We may charge a fee to release information for non-program purposes.

Blackburn Group, Inc will be responsible for any charges that may apply for release information

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

Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☒ Verification of 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 (We will not honor a request for "any" and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

   Medicare- HICN Claim#, SSDI Entitlement date, Medicare Part A, B, & D, entitle dates, Date Applied disab. benefits, Date SSDI & Amount;*If No Benefits apply please advise in writing.

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 it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining 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:** _____

****Daytime Phone:** _____

****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)