Social Security Administration

CONSENT FOR RELEASE OF PERSONAL INFORMATION

You must complete all required fields. We will not honor requests unless all required fields are completed. An asterisk **(*)** signifies a required field. **Print** unless a "signature" is requested.

PART 1—COMPLETE FOR RELEASE TO A THIRD PARTY

TO: Social Security Administration
FROM: *Name

*LAST _____ *FIRST _____ *MI _____

*DATE OF BIRTH _____ *SOCIAL SECURITY NUMBER Last 4 Digits ONLY

As required by the Privacy Act of 1974 (5 USC 552a.(b)), I hereby consent to and authorize the Social Security Administration to release my personal information from my personnel records/files to:

RECORDS DEPOSITION SERVICE, INC. P:248-357-3330 F:248-357-3337
*FULL NAME OF PERSON OR ORGANIZATION

PO BOX 5054 SOUTHFIELD MI 48086
*ADDRESS OF PERSON OR ORGANIZATION *CITY *STATE *ZIP CODE

LITIGATION
*REASON(S) FOR REQUEST

You must specify the information/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**." We will not disclose information/records unless you include the **applicable date ranges** where requested.

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

- ☐ 1. Performance Plans—all related documents
- ☐ 2. Performance Assistance Plans—all related documents
- ☐ 3. Time and Attendance records from _____ *DATE to _____ *DATE
- ☐ 4. Misconduct documentation
- ☑ 5. Other information/records(s) from my file—you **must** specify the requested records in the box below

***I want this information released for the period of** _____ *DATE **to** _____ *DATE

*MY SIGNATURE _____ *DATE _____ *PHONE

PART 2—COMPLETE IF YOU WANT A THIRD PARTY TO ACCOMPANY YOU

I hereby authorize the presence of: _____ *LAST NAME _____ *FIRST NAME _____ *MI while I access my records.

(List Personnel Records/Files)

*MY SIGNATURE _____ *DATE _____ *PHONE

CONSENT FOR RELEASE OF PERSONAL INFORMATION

I certify that I am the individual to whom the requested information or records apply, or the legal guardian of the legally incompetent adult to whom the requested information or records apply. I declare under penalty of perjury 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 obtains 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 purposes.

**SIGNATURE* **DATE*

**STREET* **CITY* **STATE* **ZIP CODE*

**RELATIONSHIP (if not the subject of the record)* **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, and Zip Code) *ADDRESS (Number and street, City, State, and Zip Code)*

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, allows us to collect this information. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent us from processing your request to release information or records about you to another person or organization without your consent.

We rarely use the information you supply for any purpose other than what we state above, however, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,

2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

Additional information regarding this program, our routine uses of your information, and other Social Security programs, is available on our internet website, www.socialsecurity.gov, or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.