State of Illinois
Department of Human Services

CLIENT AUTHORIZATION FORM

CASE NAME: _____

CASE NUMBER: _____

SOCIAL SECURITY NUMBER: _____

I authorize staff of the Department's SSI Advocacy Provider in this area, _____ .

to obtain information from my records from the Bureau of Disability Determination Services, Office of Rehabilitation Services. In particular, I authorize release of my records to the above with respect to my present claim for disability benefits and all related appeals. I understand by this authorization that the Legal Assistance Foundation has not agreed to represent me and will advise if they will accept my case after review of my records.*

I also authorize staff of the Illinois Department of Human Services to obtain information from my records or copy my records from the Bureau of Disability Determination Services, Office of Rehabilitation Services. In particular, I authorize release of my records to the above with respect to my present claim for disability benefits and all related appeals.

I also authorize that any records which are copied or any information obtained through this release may be transferred to the SSI Advocacy Provider.

In addition, I authorize staff of the Illinois Department of Human Services to release to the Office of Rehabilitation Services, Disability Determination Services, any medical and social information submitted to the Illinois Department of Human Services for purposes of establishing SSI eligibility.

This consent is subject to revocation in writing by the undersigned at any time except to the extent that the action has been taken in reliance hereon and if not earlier revoked: it shall terminate upon a reconsideration decision on my Social Security and/or SSI claim, whichever occurs later.

Any copy of this original should be considered as valid as the original.

I hereby certify that I understand that the materials requested may be protected under the Privacy Act. I authorize release of any materials protected under the Privacy Act to the individuals identified above.

Client Signature: _____ Date: _____

* If the SSI Advocay Provider decides to represent the claimant, it will submit a completed appointment of representative to be filed in the administrative record. Absent such an appointment, the SSI Advocacy Provider is not representing the claimant who released his or her records.

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