Social Security Authorized Representative Form

Claimant Information

Full Name: _____

Social Security Number: _____

Date of Birth: _____

Authorized Representative Details

Representative's Name: _____

Organization (if applicable): _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Email: _____

Authorization Scope

Permission Granted For	Yes	No	Notes
Accessing Social Security Records	[ ]	[ ]	
Filing Appeals	[ ]	[ ]	
Managing Benefits	[ ]	[ ]	
Other (specify): _____	[ ]	[ ]	

Declaration

I authorize the above representative to act on my behalf in matters related to Social Security benefits.

Claimant Signature

Signature: _____ Date: _____

Representative Signature

Signature: _____ Date: _____