

**KENTUCKY  
DEPARTMENT OF WORKERS' CLAIMS  
SOCIAL SECURITY RELEASE FORM**

I, \_\_\_\_\_, having filed an Application for Resolution of Occupational Disease or Hearing Loss Claim for workers' compensation benefits, do hereby authorize the Social Security Administration to release or disclose the Department of Workers' Claims any information in their possession concerning my benefit or wage earnings.

Signed at \_\_\_\_\_, Kentucky, this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Plaintiff's Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Witness Signature