

COUNTY OF

AUTHORIZATION FOR RELEASE OF INFORMATION

Case Name
Case Number
Worker Name
Worker Number
Worker Telephone
Date

TO:

I, _____, residing at _____
Applicant/Client Name Applicant/Client Address

_____, hereby authorize you to release to
Applicant/Client City/State/Zip Code

_____ specific
Name of Agency, Institution, Individual Provider

information requested by this agency which I cannot provide concerning: _____

This form was completed in its entirety (or read to me) prior to signing. I understand that I have the right to receive a copy of this authorization upon my request. Copy requested and received: Yes No Initial

This release is valid for 12 months from the signature date of the client or until revoked by the client.

Signature of Applicant/Client	Birth Date	Maiden Name of Mother
Birthplace	SSN	Date
Signature of Spouse of Applicant/Client	SSN	Date
Birthplace of Spouse	Birth Date	Maiden Name of Spouse's Mother