

## Authorization for Release of Information

Date:

County:

**Information due date:**

Worker Number:

Worker Name:

Phone:

Email:

[Redacted area]

Dear [Redacted]

This form gives you permission to share information with the Department of Human Services (DHS).

Please fill out this form and send it back to me by:

- Mailing it in the enclosed postage paid return envelope,
- Bringing it to my office at:
- Faxing it to:

If you have any questions, please call me at the phone number above.

### Information Requested

[Redacted area]

Please share this information with the Department of Human Services. I give my permission to the person or agency named above to share information about my family or me. I will not hold this person liable for giving information, even if it's confidential. This permission stops

Name (please print)	Signature	Date

Please use the next page to provide a response to this request.

