Release of Information Form

Client Name:	**Last 4 of SS #:**
D.O.B	

I ____ request and authorize the following agencies, person(s), programs, etc. to use or disclose information to and from Community Living Assistance Support Services, Inc. in all matters concerning my Financial, Social, Legal, Developmental, Educational, Vocational, Psychological, Psychiatric, Medical Evaluations and other data pertaining to housing, entitlement and governmental benefits. This release includes authorization ***for Community Living Assistance Support Services Inc. to change billing addresses on my account with the above named company.***

I understand that I have the right to revoke the authorization at any time. If I revoke authorization, I must do so in writing and present it to the person/facility/agency that was authorized to release the information. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that once the above information is disclosed, the recipient may re-disclose it and the information may not be protected by federal or state privacy laws or regulations. I understand that authorizing or disclosure of the information identified above is voluntary and that this authorization to release my information is considered active while Community Living Assistance Support Services remains my Representative Payee. I understand that I do not have to sign this form to receive Representative Payee services from Community Living Assistance Support Services, Inc.

Clients Signature:	**Date:**