Benefit Planning Services
AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

TO:	FROM: Specialist: Phone: Fax:

☐ **I hereby request and authorize you to release to ___________________ the following types of information, which you have pertaining to me**

_ **I hereby authorize _________________________ to release to you the specified information requested.**

THIS CONSENT IS SUBJECT TO REVOCATION (IN WRITING) AT ANY TIME EXCEPT TO THE EXTENT THAT THE ACTION HAS BEEN TAKEN THEREON.

COMPLETE BELOW

Agency or organization	Date of Client Authorization	Client's Initials	Agency or organization	Date of Client Authorization	Client's Initials
Social Security Administration			Heating Assistance Program		
Unemployment Insurance (Department of Labor)			Alaska Temporary Assistance Program		
Division of Adult Public Assistance			Office of Public Advocates		
Alaska Housing and Finance Corporation			Authorized Representative		
Division of Vocational Rehabilitation			Other		
Veteran's Administration			Other		

(OPTIONAL) THIS RELEASE OF INFORMATION WILL EXPIRE WITHOUT EXPRESSED REVOCATION ON ___________________ (Give a specific date, event or coordinator.)
Date

____
*Parent or Guardian Signature

X_________________________________
Client's Signature

X_________________________________
Client's Social Security Number

____
Client's Maiden Name (or any other name used)

X_________________________________
Client's Birthdate (Month, Date, Year)

____
**Witness' Signature Date

____
** Witness' Signature Date

***IF A CLIENT IS A MINOR, SIGNATURE OF PARENT OR GUARDIAN IS REQUIRED**
****IF UNABLE TO WRITE HIS OR HER NAME, THE CLIENT SHOULD ENTER AN X @ OR OTHER MARK, SIGNATURES OF TWO WITNESSES ARE REQUIRED.**