



Community Action Program East Central Oregon Authorization for Release of Information

To Our Clients: We can help you better if we are able to work with other agencies that know you and your family. By signing this form you are giving your permission for these organizations to share information about your situation.

Name: _____ D.O.B: _____ Last 4 digits of SS#: _____

By marking the boxes I authorize the following individuals and/or agencies to provide information to CAPECO

- | | |
|---|--|
| <input type="checkbox"/> Social Security Administration | <input type="checkbox"/> Local Housing Authority |
| <input type="checkbox"/> Veteran's Affairs | <input type="checkbox"/> CTUIR/Bureau of Indian Affairs |
| <input type="checkbox"/> Utility Companies | <input type="checkbox"/> OTHER CAPECO Departments/Programs |
| <input type="checkbox"/> Cable and Phone Companies | <input type="checkbox"/> Family Members or Other Individuals, please list: |
| <input type="checkbox"/> Creditors | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Hospitals/Clinics/Care Facilities/Physicians | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Mental Health Department(s) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Public Health Department(s) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Landlord | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Court House _____ County | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Parole/Probation _____ County | <input type="checkbox"/> _____ |

Including authorization to discuss records of:

- | | |
|---|---|
| <input type="checkbox"/> Contract Agreements | <input type="checkbox"/> Landlord/Tenant issues |
| <input type="checkbox"/> Loan Agreements | <input type="checkbox"/> Income/Financial and Non-financial Resources |
| <input type="checkbox"/> Monthly Billing | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Statement Information | <input type="checkbox"/> Medical Bills |
| <input type="checkbox"/> Employment/Wages/Personnel | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Rental/Lease Agreements | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Address Correction/Update | <input type="checkbox"/> _____ |

Purpose: *The information received will be used to evaluate my situation and to plan for and coordinate services for me or for other purposes such as:* _____.

I agree that the agencies and individuals listed above may share and exchange information about me and my circumstances. YES NO

This permission is good for one year three years five years from date of signature OR until _____.

I can cancel this at any time but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing of my own accord and have not been pressured to do so.

Client Name

Client Signature

Date

CAPECO Staff Name

CAPECO Staff Signature

Date

CAPECO Staff Name

CAPECO Staff Signature

Date

To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by law.