CONSENT FOR RELEASE OF INFORMATION

_____ COUNTY DEPARTMENT OF SOCIAL SERVICES

***Privacy Statement**: Providing your social security number is voluntary. However, you may be required to sign consent for the release of information if needed to make a determination about your eligibility for benefits and services. Federal and State laws require health and human services agencies to protect the privacy and security of applicant/recipient information. Information released to another entity may potentially be shared with another agency, in which case state or federal law may not protect the information.*

Please read this form carefully, and ask questions if you do not understand.

Name of Applicant/Recipient: (Last, First, Middle Initial)	SSN (optional)	Date of Birth:	
Street Address:	City:	State:	Zip code:

1. **I Authorize**: (Name of Person/Agency)			
Street Address:	City:	State:	Zip Code:
2. **To Release Information to:** (Name of Person/Agency to receive information)			
Street Address:	City:	State:	Zip Code:
3. **The following information**: (Be Specific)			
4. **The information identified above will be used for**: (list each purpose)			
5. **This authorization remains in effect until**: (up to a maximum period of one year)			

This consent is voluntary and remains in effect until the above date. I understand that if I do not give an expiration date or event, this authorization is valid for a period of up to one year. I also understand I may cancel my consent at anytime by contacting the agency and that I will be asked to sign the Written Cancellation of Consent Section below. The cancellation does not affect information already shared.

I understand that if my record contains information relating to health or medical conditions, substance abuse *, psychological or psychiatric conditions, this disclosure may include that information. I also understand that I may refuse to sign this authorization. (* separate consent required)

A photocopy of this consent is as effective as the original. The information may be shared in writing, orally, or by electronic transmission, unless otherwise stated.

Applicant/Recipient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Signature of witness (if needed):_____ Date: _____

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Written Cancellation of Consent

I, _____, cancel my consent given
Applicant/Recipient Name (please print)

to _____ to share information. I understand that

cancellation does not affect information already shared.

Applicant/Recipient Signature: _____ _____
Date

Witness (if needed): _____ _____
Date

Date Consent was revoked: _____ _____
Signature of Staff

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(Completed by agency staff when request is made by telephone)

Verbal Cancellation of Consent

I do herby attest to the verbal request for cancellation of this consent by:

_____ on _____.
Applicant/Recipient's name Date

The applicant/recipient was informed that any action taken on this consent prior to the cancellation date is legal and binding.

_____ _____
Staff Signature Date

Distribution: ☐ To agency/person from whom information is sought ☐ Case file ☐ Applicant/Recipient

The North Carolina Division of Social Services does not discriminate against any person on the basis of race, color, national origin, disability, sex, age or political beliefs in the admission, treatment, or participation in its programs, services and activities, or in employment