

CONSENT TO RELEASE INFORMATION

I _____, hereby give my

(1) (Circle One: Applicant / Recipient / Legal Guardian)

permission to the Department of Human Services, Benefit, Employment and Support Services Division (BESSD) to release information from their records pertaining to me or my family to:

(2) (Name of Person / Organization)

(3) The information to be reviewed / released is limited to the following: _____

(4) This information is to be used for: _____

(State Purpose)

(5) This consent is good until _____ (not to exceed one year from date signed) unless I cancel it in writing to DHS-BESSD)
(month) (day) (year)

I understand why the information is being requested, how it will be used, and that this consent is time limited for my protection.

(6) (Signature of Applicant / Recipient / Legal Guardian)

(7) (Date)

(8) (Address of Applicant / Recipient)

(9) (Social Security No. or Birthdate of Applicant/Recipient)

I hereby agree that the information released will be used only for the purposes stated above and will not be released to any other individual, agency, or organization (HRS 346-10).

(10) (Signature of person receiving / reviewing information)

(Date)

Return Completed Form To:

(11) (Stamp Unit name and address)

(12) Worker's Name

Telephone No.

Complete two (2) copies:

Original – Case Record

Copy – Client