04/2019

Authorization for Exchange of Information-
Multi Agency Release

Full Name:____

Social Security Number:________________________ Date of Birth:__________________

I have accepted the services of ____________________ . My signature below indicates that I have authorized any representative of this organization to release and receive both written and verbal information relating to my circumstances for the purpose(s) designated below. You are hereby directed to furnish such information to ______________________ staff on my behalf.

I hereby authorize _________________________ to exchange information with the following agencies or individuals:

____Assistive Technology Partnership
____Client Assistance Program
____General Assistance
____Local Housing Authority (specify)
____
____Veterans Administration
____Other: ___________________

____Nebraska Department of Health and Human Services
____Nebraska Self-Employment Services/NebraskaAbility
____Nebraska VR (Vocational Rehabilitation)
____American Job Center Network (DOL Career Center)
____DHHS – Online Account Access
____SSA – my Social Security Account Access
____Other: ______________________________

For the Purpose of:

___X_ BENEFITS PLANNING AND ASSISTANCE / EMPLOYMENT PLANNING

______ OTHER (Specify):____

- I understand that the information to be released may include information protected under Federal Confidentiality Regulations and cannot be disclosed without my permission.
- I may revoke this authorization for exchange of information by providing written notice, except to the extent that action has already been taken in reliance on the authorization. I can request to have the exchange of my information limited to satisfy a specific need or privacy concern.
- I consider a photocopy of this authorization to be as valid as the original.
- I authorize information to be exchanged by facsimile, U.S. Postal Service, electronically or phone.
- I hereby release ____________________ from all legal liability that might arise from its release of information or the re-disclosure of the information by the recipient.

This authorization will expire <u>one</u> <u>year</u> from the date of signature, unless revoked or otherwise specified.

_______________________________________ ____________________
Client Signature Date

_______________________________________ ____________________
Authorized Representative Signature Date