CONSENT TO RELEASE, OBTAIN OR EXCHANGE INFORMATION

Participant Name: ____ **Date of Birth**:__________________

Address:____

FROM:	Name: 1535 Lafayette Street Waterloo, IA 50703 PH (319) 291-2065 FAX (319) 232-6484	**TO:**	Agency: Contact Person: Address: Phone: FAX:

CONSENT TO OBTAIN OR EXCHANGE THE FOLLOWING CHECKED ITEMS

HOUSING ASSISTANCE ☐ Rent ☐ Deposit ☐ Mortgage ☐ Homelessness	**UTILITY ASSISTANCE** ☐ Water ☐ Gas ☐ Electric ☐ Fuel	**EMPLOYMENT EXPENSES** ☐ Equipment ☐ Clothing
BILL ASSISTANCE ☐ Landline Phone ☐ Cell Phone	**EXPENSES** ☐ Medical Bills ☐ Dental Bills	**EDUCATION** ☐ Books ☐ Materials
ASSISTANCE FOR CHILDREN ☐ Internet for School ☐ School Uniforms/School Clothing ☐ Child Care	**TRANSPORTATION** ☐ Bus Pass ☐ Vehicle Registration	
HOUSEHOLD ASSISTANCE ☐ Household Items ☐ Personal Hygiene ☐ Food ☐ Personal Protective Equipment (PPE)		**OTHER:**

Briefly explain the purpose for this release of information	**To communicate with Vendor/Agency who will receive payment by verifying any necessary information for the above selected program assistance.**

Please read before signing below.

*I understand that the consent to Release, Obtain or Exchange Information form is limited to the agencies, groups or persons named, and this information is not to be passed on to anyone else or to be used for any purpose other than those specified.

*I understand that I have the right to see this information at any time. I can revoke my consent by writing to both the persons giving and the persons receiving the information. But any information already released may be used as stated on this consent. I understand the information is needed to plan services or to determine eligibility for services. This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked sooner. I have read this release form, or it has been read to me and I understand its content.

*Federal and/or State law specifically requires that any disclosure or re-disclosure of AIDS-related information must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_______ **This authorization is a one-time disclosure and is valid for 90 days from the date of signature**
______ **This authorization becomes invalid one year from date of signature or when case is closed**

See also Chapter 228 of the Iowa Code and Section 141.23(3) of the Iowa Code and other applicable laws.

____ ____________________
Participant Signature Effective Date

____ ____________________
Staff Signature Date

Please check and initial one of the below:

☐ I declined a copy of this release: ____________________ Participant Initials
☐ I received a copy of this release: ____________________ Participant Initials

CC: Original to case file; copy to participant/legal representative 8/2020