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:____________________ SS#:______________________

Name:_______________________________ D.O.B:____________________ SS#:______________________

Children: ____________________________ ____________________________ ___________________________

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

- □ Department of Human Resources (Self-Sufficiency, Child Welfare, Seniors & People with Disabilities)
- □ Oregon State Employment Department
- □ CAPECO Workforce Investment Act Program
- □ CTUIR/ Bureau of Indian Affairs
- □ Mental Health Department
- □ Public Health Department
- □ Social Security Administration
- □ Servicepoint/HMIS
- □ Parole/Probation_____________________ (specify County)
- □ Landlord
- □ Local Housing Authority
- □ Other: ____________________________
- □ Other: ____________________________

Including records of:

- □ Family History
- □ Employment/Unemployment
- □ Elevated Blood Lead Level Cross Reference
- □ Medical/Psychiatric Treatment
- □ Education Reports
- □ Alcohol/Drug Treatment
- □ Resources, financial and non-financial
- □ Housing Status/ Section 8 Status
- □ Landlord/Tenant issues
- □ Mental Health Services
- □ Other:_____________________________
- □ Other:_____________________________

Alcohol/Drug, Mental Health and Medical Records include all aspects of diagnosis, treatment and prognosis. Educational records include both behavioral and progress reports.

***Purpose: The information received will be used to evaluate my situation and to plan for and coordinate services for me and my family or for other purposes specified:*____.**

I agree that the agencies and individuals listed above may share and exchange information about my family and circumstances. □ YES □ NO This permission is good for one year 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 on my own and have not been pressured to do so.

_______________________________ _______________________________ __________________
Client Signature (Main Applicant) (Secondary Applicant) 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.

This is a true copy of the original authorization document ___________________________ (Agency Staff Person)

December 2016