AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Date: _____

Individual's Name: _____

Address: _____
Street City State/Zip

Date of Birth: _____
Month/Date/Year

I, _____ hereby authorize _____
Applicant's Name

To release medical, psychological, social narrative and other pertinent information to The Arc of Howard County as presently requested by same. Authorization is extended for this request only and at this time only.

I understand that the information is requested for the purpose of assisting the requesting agency in serving me now and/or in the future.

I understand that all information will be treated in a strictly confidential manner.

Signature of Applicant: _____ Date: _____

Parent/Guardian: _____ Date: _____
(must sign if Applicant is under 18 years of age)

Witness: _____ Date: _____
(must sign if "X" is used)

Agency Representative: _____ Date: _____

Signature of Applicant: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Person Completing form: _____ Date: _____