CONSENT TO RELEASE INFORMATION

Name of Person for whom information is requested: _____

Date of Birth: _____ Social Security Number: _____-_____-_____

☐ I hereby authorize: _____ to release the following information to the Maryland Department of Human Services/ Department of Social Services.

☐ I hereby authorize the Maryland Department of Human Services/Family Investment Administration-Department of Social Services to release the following information to:

_____.

(Please check information to be released)

☐ Financial Records (assets, loans, accounts, investments, etc.)

☐ Employment/Payroll/Wage records: Dates, Wages, Withholding, etc.)

☐ Benefit/Grant Records (Dates, Amounts, Beneficiaries, etc.)

☐ Medical records from _____ to _____.
(including any physical examination and lab work, mental status evaluation, general progress notes, and transfer or closing summary) for the purpose of verifying a disability.

☐ Other (specify)_____

This consent may be revoked at any time except to the extent that action has been taken in reliance upon it.

Unless I specify an earlier date, this consent expires sixty (60) from the date it is signed.

Signature: _____ Date: _____

Date this consent expires, if earlier than 60 days:_____

Parent or Guardian Signature (for a child under age 18):_____
The information may be submitted by dropping it off at the Department of Social Services, mail, fax or e-mail to the intended recipient.

This information is used under the guidelines established in The Privacy Act of 1974 5 U.S.C. § 552a As Amended and the **Commercial Law Title 14. Miscellaneous Consumer Protection Provisions SUBTITLE 35. Maryland Personal Information Protection Act. MD. Commercial Law Code Ann. §14-3502 (2012).**

Mail to:_____ **Attention of:** _____

_____ **E-mail to**: _____

FAX to: _____ **Attention of:** _____