

County of San Mateo

**VOLUNTARY
CONSENT FOR RELEASE OF INFORMATION OR RECORDS**

Name: _____
(Agency doing Intake)

Date: _____

Re: _____
(Name of Client) (Social Security Number) (Date of Birth)

(AGENCY OR INDIVIDUAL FROM WHOM INFORMATION IS REQUESTED)

- TO:
- | | | |
|--|---|--|
| <input type="checkbox"/> Employers | <input type="checkbox"/> Parole/Prob. Facilities | <input type="checkbox"/> Mental Health Division |
| <input type="checkbox"/> Insurance Company | Officers | <input type="checkbox"/> Immigration and |
| <input type="checkbox"/> Landlords/Residence Mgr/
Housing Authority | <input type="checkbox"/> Social Security Admin. | Naturalization Services |
| <input type="checkbox"/> Providers of Health
Services | <input type="checkbox"/> Schools/Universities | <input type="checkbox"/> Disability Services Advocate |
| | <input type="checkbox"/> Credit Inquiry/Financial
Institutions | <input type="checkbox"/> Any Community Based
Organization |

This Authorizes the Release of Information to San Mateo County Human Services. This information will be used for determination of eligibility for the CASH ASSISTANCE PROGRAM FOR IMMIGRANTS (CAPI).

The information being requested may be confidential and protected from disclosure by Federal and State Rule and regulations. Further, this release will be valid for 12 months from signature date of Client and/or Guardian unless it is revoked by the Client and/or Guardian. NOTE: The Client and/or Guardian may revoke this authorization at any time by furnishing written notice of revocation.

I hereby release and hold harmless all of the agencies/organizations designated in this document from all liability and claims of any kind, related to the release and sharing of information, as described in the foregoing, provided by any/all of the agencies and/or organizations indicated. I understand that I have the right to receive a copy of this consent to release.

Signed: _____
(Client/Parent/Guardian)

Date: _____

Signed: _____
(Witness)

Date: _____