

Disability Advocacy Client Release of Information

Date:

Client Name:

Date of Birth:

Client Address:

I hereby authorize (Name of Organization/Individual releasing information):

To release the following information to (Name of recipient/agency):

Description of information to be released:

Purpose of release:

This authorization will expire on (date/event):

Additional limitations or instructions:

Signatures

Client Signature:

Date:

Witness or Guardian Signature (if applicable):

Date: