



AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, authorize you by copy of this form to provide any information in your records, documents, files, etc. to any representative of Community Concepts. This authorization includes but is not limited to any information relating to criminal history, physical health, mental health, drug screen results, employment, finances, education, and legal documents. This authorization also includes release of information from other individual agencies, whether public or private, concerning myself or my children.

Name: _____

Address: _____

Phone Number: _____

Date of Birth: _____

Social Security Number: _____

Insurance/Medicaid Number: _____

You are hereby absolved of any responsibility for disclosure of any information pursuant to this authorization and any liability is hereby waived. I understand that this information will be obtained and maintained in a confidential manner by representatives of Community Concepts. I also understand that this form is valid for one year from the date of this form.

Client Print Name

Client Signature

Date

Community Concepts Print

Community Concepts Signature

Date

