Authorization to Release Information

Your Right to Privacy: You are being asked to sign a release of information that will allow agencies providing services to share information about you and your family*. This information will allow these agencies to serve you better by helping them coordinate services and work together toward common goals.

Your signature on this form is not required for treatment, payment, enrollment or eligibility for benefits. However, services requiring exchange of information with other providers may be limited without this specific authorization. You may revoke or cancel this authorization in writing at any time. You may also request that particular information be considered confidential. Your request will ensure confidentiality of this particular information even if you have signed the release of information agreement. Your right to privacy is very important to all service providers. Only information that is essential to providing services will be shared with other agencies.

Name:	
Case Number:	
Date of Birth:	

By signing below, I authorize the release of the following information and records for myself and my minor dependents (*list names*).

Name:	
Name:	
Name:	
Name:	
Name:	
Name:	

Indicate Yes or No (Y/N)	
	Medical Information (*medical history, assessments, testing, lab work, diagnosis, medical information related to illness, summaries and progress reports, admission and discharge summaries, referral information*)
	Personal Identification
	Employment/Work Related Information
	Financial Information
	Educational Information (*transcripts, current grade level, testing*)
	Legal History
	Other:

I hereby authorize **Integrated Refugee and Immigrant Services (IRIS)** to release information to/or to receive information from the following agencies indicated below:

Indicate Yes or No (Y/N)			
	Church World Service		*Health Screening Provider*
	U.S. Department of State, Bureau of Population, Refugees and Migration		*Employer/Work Verification*
	U.S. Department of Health and Human Services, Office of Refugee Resettlement		*Vocational Rehabilitation Services*
	U.S. Citizenship and Immigration Services		*English Language Schools/Training Centers*
	U.S. Social Security Administration		*School*

	State Office for Refugees		*Other:*
	Local Department of Social Services		*Other:*
	Other Local Resettlement Agency		*Other:*

I authorize the sharing of this information for the limited purposes of determining eligibility for services and assistance, coordinating care, and meeting the goals of my family service plan. I understand that this information may be shared by phone, fax, scan, mail, e-mail or in person.

Additional Special Instructions, if applicable:

I understand that a copy of the completed and signed authorization form will be made available to me at my request. This authorization remains in effect until one (1) year from the date indicated below. I understand that I may revoke this authorization in writing at any time by submitting a written statement of revocation to the originating office listed above. A copy of this authorization is as valid as the original.

Signatures:	
Date:	
Client Name:	
Client Signature:	
Parent, Guardian, Custodian for (M2-M6) Name, if applicable:	
Parent, Guardian, Custodian for (M2-M6) Signature, if applicable:	
Staff Member Name:	
Staff Member Signature:	
Interpreter Name:	
Interpreter Signature:	

*This request is made pursuant to the authority granted by the cooperative agreements between Church World Service (CWS) and the U.S. Department of State, Bureau of Population, Refugees, and Migration and, as applicable, between CWS and the U.S. Department of Health and Human Services, Office of Refugee Resettlement.