Name: _____ SSN: _____ DOB: _____

I the undersigned, hereby authorize Disability Rights Iowa-Work Incentive Planning and Assistance to:

_x__ release _x__ receive

any and all pertinent information in my file.

The information is needed to:

Assist in Social Security Work Incentive benefits analysis and planning.

___ Other: (specify) _____

This permission is granted to:

___ Case Management
___ Community MH Center
___ Dr. _____
___ PROMISE Jobs
___ Veterans Administration
_X_ Social Security
_X_ Disability Rights Iowa
___ _____
___ _____

___ County Social Services
__ Iowa Dept. of Human Services
__ American Job Center
___ Regional Housing Authority
___ Vocational Rehabilitation
__ Illinois Dept. of Human Services
___ _____
___ _____
___ __ _____

This authorization shall expire ONE YEAR from the date it is signed, unless otherwise specified _____. I understand that I may cancel consent at any time by submitting a written request to Disability Rights Iowa and that any cancellation will not affect information already released.

Signature/Guardian Signature _____ Date _____

Specific Authorization for Release of Information protected by State or Federal Law.

I specifically authorize the release of data and information to:

Substance abuse ____ Mental Health ____ HIV-Related information ____

Signature/Guardian Signature _____ Date _____

mj