Disability Rights Iowa
Work Incentives Planning & Assistance

Iowa & Illinois Work Incentives Planning & Assistance Third Party Release

Contact Information

Name (First, Middle Initial, & Last): _____

Social Security Number: _____ Date of Birth: _____

I, the undersigned, hereby authorize Disability Rights Iowa Work Incentives Planning and Assistance to **release** and **receive** any and all pertinent information in my file. The information is needed to assist in Social Security work incentives benefits analysis and planning.

This permission is granted to the following agencies and/or individuals:

- [x] Social Security Administration (SSA)
- [x] Disability Rights Iowa (DRI)
- [ ] Iowa Department of Health and Human Services (HHS)
- [ ] Illinois Department of Healthcare and Family Services (HFS)
- [ ] Iowa Vocational Rehabilitation Services (IVRS)
- [ ] Illinois Department of Human Services (IDHS): Division of Rehabilitation Services (DRS)
- [ ] Employment Service Provider _____
- [ ] Other _____

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/Federal Law

I specifically authorize the release of data and information regarding:

- [ ] HIV-Related Information
- [ ] Mental Health
- [ ] Substance Abuse

Signature/Guardian Signature _____ Date: _____