SSN

Date Signed

CENTER Jou ACCESSIBLE LIVING

Authorization for Release of Information

I hereby give my informed consent for the release of the following information about

1. Information regarding Social Security cash benefits, state benefits, and other

D.O.B.

A Disabi	ility R	Rights
& Resou	•	_

Consumer Name

Consumer Signature

501 S 2nd Street Suite 200 Louisville, KY 40202 VOICE: (502) 589-6620 FAX: (502) 589-3980 Toll Free: 844-689-6620

1051 N. 16th Street Suite C Murray, KY 42071 VOICE: (270) 753-7676 FAX: (270) 753-7729 Toll Free: (888) 261-6194

1830 Destiny Lane Suite 108 Bowling Green, KY 42104 VOICE: (270) 599-0911 FAX:(270) 599-0912

www.calky.org

benefits as applicable. 2. Information regarding employment goals. This information may only be released to: a Center for Accessible Living Community Work Incentive Coordinator (CWIC) For the following reason(s): Benefits Planning and Work Incentives Counseling and Assistance All matters related to a consumer's records are considered confidential and are treated as such by the employees of the Center for Accessible Living. Information will not be shared or released without the consent of the consumer (unless court-ordered to do so.) This consent will expire within six months (6) or if consent is withdrawn in writing by the consumer. I have had this explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may revoke this consent in writing at any time. A photographic copy of this authorization shall be considered as effective and valid as the original.

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