

Storey County Health and Community Service Department

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

NOTICE: By signing below, you (1) allow the Storey County Health and Community Services (SCHCS) staff to release, exchange, receive and disclose information about you and your family' with the person/agency listed below; (2) authorize the person/agency listed below and individuals to release, exchange, receive and disclose information concerning you and your family's participation in other SCHCS programs, or with other agencies, to the SCHCS program staff for the purpose of determining your eligibility to participate in the program(s) and coordinate services; (3) release and indemnify SCHCS, their members, trustees, officers, employees and volunteers from any liability for losses, damages or claims of any type arising out of actions taken by SCHCS in reliance upon this Authorization to Release, Exchange, Receive and/or Disclose Information, hereafter known as "Authorization".

AUTHORIZATION: I authorize SCHCS to release/receive identifying information including family names, addresses and phone numbers; as well as information from our case file regarding me and my family for the purpose of assessing my family's eligibility for the program, and coordinate services with the following person/agency (**only one person/agency per form**). I understand that all information obtained will be kept confidential.

I, _____ (print name), give permission for Storey County Health

and Community Services and _____ (individual/organization)

to release, exchange, receive, share and/or disclose personal, medical and financial information.

NOTES:

Client's Signature

Date

Client's Printed Name

NOTE: This form will remain in effect until one year from the client's signature date or cancelled in writing by the client.