



Permission for Release of Information

_____ give my permission to Life Options of West TN, Inc and its associates to release to or receive information about me with/from:

____ Friend ____ Family Member ____ Emergency Contact
____ Agency ____ Other (explain) _____

_____ Name of person or agency

this includes information about my children:

Name:	Birthday:
_____	_____
_____	_____
_____	_____
_____	_____

For the purpose of: Providing representative payee services.

This release takes effect on: _____ and expires on: _____
(This release can be used for one year only)

Because being a representative payee is an ongoing contractual relationship with the Social Security Administration, this release is effective for a 1(one) year period.

I understand that I can cancel this release at any time in writing.

I understand that my disclosure of records concerning treatment of alcohol or drug abuse and/or HIV/AIDS is protected by Federal Law which says that I have to give my permission to share this information.

_____	_____
Client Signature	Date
_____	_____
Parent or Guardian	Date
_____	_____
Staff Member	Date
_____	_____