Reset Form

Ohio Department of Job and Family Services

APPLICANT/RECIPIENT AUTHORIZATION FOR RELEASE OF INFORMATION

Office Use Only	
Applicant/Recipient Name	**Case Number**
Name of CDJFS Representative/Unique Identifier/Date	

I, _____, hereby authorize FCDJFS _____ to disclose
(Name of Individual) **(Name of covered entity, such as CDJFS, employer, etc.)**

the information listed below to_____ for the purpose of determining
(Who will receive the information?)

eligibility for cash assistance, medical assistance and/or food stamp benefits; or for the following reason(s): _____
Coordination of services.

Information to be released: Information regarding Public Assistance benefit eligibility administered by FCDJFS and other case information.

By signing below, I understand that:

This authorization shall expire on _____ or until revoked by me in writing, whichever comes first.
(Date or completion of "event"- reason the signed authorization is needed)

I have the right to revoke or cancel this authorization at any time by providing notice in writing to the following address:
1721 Northland Park Ave. Columbus, Ohio 43229

The revoking or canceling of this authorization does not affect the use or disclosure of information that occurred prior to the date that authorization was canceled.

Any information used or disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it may no longer be protected by federal or state law.

This authorization is **NOT** for the release or use of protected health information (PHI) – please use the appropriate medical release authorization form.

I am aware of my responsibilities to report completely and fully all facts that bear upon my eligibility for all cash assistance, medical assistance and/or food stamp benefits. I realize if the requested information reveals I have improperly reported my situation, the information may be given to the prosecuting attorney for possible civil action or criminal prosecution.

Completion of this form is voluntary, but necessary to determine eligibility for cash assistance, medical assistance and/or food stamp benefits.

Signature of Applicant/Recipient or Authorized Representative	**Date**	**Representative's Legal Authority to Applicant/Recipient (Such as parent, guardian, power of attorney, auth rep, etc.)**

Please reply in the space below, sign and date.

_____

_____

_____

_____

Signature/Title of Person Supplying Information **Telephone Number** **Date**