LAS ANIMAS COUNTY
DEPARTMENT OF HUMAN SERVICES

Name of Individual (Grantor) of authorization: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Some sources of necessary information such as insurance companies, banks, savings and loans associations, as well as physicians, Clinics, hospitals, nursing homes, etc., require specific individual authorizations other than the statement signed as part of an assistance Application form before releasing such information concerning the applicant or dependent members of the applicant's family (whose needs are included in my assistance grant). In recognition of this fact, the source(s) listed below is herewith authorized to release such information as is required by the above named County Department of Social Services, which is an agent of the State Department of Social Services.

I understand that the State and Federal Law mandate that applicants for public assistance must furnish necessary information to assist the Department of Social Services to verify statements and/or conditions, and prevent misrepresentation and fraud. I further understand the State of Colorado has authority for solicitation of this information under Title 26, Colorado Revised Statutes, Article 2, Section 107; Title 45, Code of Federal Regulations, Part 233, Section IO (A) (11)(8); and Income Maintenance, Volume 3, Section 3.110.

In regards to medical records, I further understand that it may be necessary for the Dal Services to release my medical records to a physician clinic, hospital, or nursing home. This release may be required so a comparison may be done of my previous disability and current medical condition, In recognition of this fact, I declare my signature constitutes a full authorization for release of the medical records *or* any related medical material provided by me, my physician clinic, hospital *or* nursing home as required by the above named County Department of Social Services, the State Department of Social Services, and its agents. I understand that it is mandatory to give my consent to obtain necessary and failure to do so may result in the denial or termination of assistance.

I herewith release and agree to hold harmless the listed source(s) of any and all liability to me for releasing information, medical, or otherwise. This release is not applicable to non-recipient spouse or others whose needs are not included in the assistance grant. No authorization is given for information prohibited from disclosure to County Departments of Federal, State, or Common Law.

This authorization is granted only in connection with its use in administration of the public assistance program and for no other purpose. It shall continue in effect until such time as I state in writing to the above named County Department of Human Services that is no longer valid.

Name of source (_s) (Please provide the full legal names and contact information for the individual(s) you as the grantor are providing authorization for Release of Information below:

[Continue to the second page. This document requires a Notary signature to ensure validity of identity]

LAS ANIMAS COUNTY
DEPARTMENT OF HUMAN SERVICES

Print Name (Grantor of ROI/Client)

Signature of applicant or recipient (first/middle/last) Date

State of Colorado
County of _____

Signed and sworn to [or affirmed] before me on _____, 20____

by _____ (name(s) of individual(s) making statement).

_____
(Notary's official signature)

_____
(Title of office)

_____
(Commission Expiration)

[Notary Stamp]