Human Resources Administration
Department of Homeless Services
Department of Social Services

AUTHORIZATION TO RELEASE CASE INFORMATION
Department of Social Services (DSS)

Client's First and Last Name:	Client's Date of Birth (DOB):
HRA or CARES Case Number:	
Client's Current Address:	
Client's Telephone Number:	
Client's Email Address:	
Time Period for Information Being Requested:	
Describe Issue and Request: _____	

Please note that this form should NOT be used to authorize the release of any protected health information, including information related to Medicaid, HIV-AIDS, mental health and/or substance use information. To authorize the release of these types of information, please use the HIPPA Authorization Form (**OCA-960**).

(Turn Page)

Please check one:

☐ Release of HRA-related case information ☐ Release of DHS-related case information

I, or my authorized representative, request that my case information be released to the below elected official, non-profit agency, or community-based organization for assisting me with my case-related issues.

Name of Requestor and Office Affiliation

Contact Number

Name of Advocate

Contact Number

Signature of DSS Client

Date

Please Note: This authorization will expire one year from the date of signature.

I have the right to revoke my authorization at any time by writing to the Department of Social Services, Office of Constituent Affairs, 150 Greenwich Street, 35th Floor, New York, NY 10007. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.