



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: _____ _____ _____	

(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.