Hastings Family Service

RELEASE OR REQUEST OF INFORMATION

I, _____ hereby authorize Hastings Family Service to seek and /or release information concerning me and / or my family which may be helpful in assessing my situation. The authorization shall continue in effect until either I revoke in writing or the services provided to me are completed or terminated. I permit Hastings Family Service staff to ask and give information about me to the agencies and or individuals checked below:

☐ CDA

☐ CAP Agency

☐ Dakota County:_____

☐ Hastings Area Faith Community: _____

☐ Leasing Property Owner or Management: _____

☐ Employer: _____

☐ Medical Clinic or Provider:_____

☐ Rivertown Eye Care

☐ Hastings Dental

☐ Utility Company:_____

☐ Other: _____

☐ Other: _____

_____ _____ _____

Applicant's Signature Date Applicant's Date of Birth

_____ _____

Hastings Family Service Signature Date