S.N.E.S.A.A.
Southern New England Social Assistance Association

Authorization for Release of Information

S.N.E.S.A.A.
P.O. Box 0409 Swansea, MA 02777
Phone: 774-365-4441 Fax: 774-365-4442
info@snesaa.org www.snesaa.org

Agency/Organization Information:

Name: _____

Address: _____

_____

Phone: _____

Contact Person: _____

Client Information:

Name: _____

Address: _____

_____

Phone: _____

[ ] **I hereby authorize the provider or agency named above to release the following information to Southern New England Social Assistance Association (S.N.E.S.A.A.).**

_____

[ ] **I hereby authorize Southern New England Social Assistance Association (S.N.E.S.A.A.) the right to request a change of address forms for the following types of Accounts Payable and Documentation:**

____ Bank Records
____ Utility Bills
____ Tuition
_____ Medical Bills
_____ Credit Card
_____ Insurance
____Legal
____Court Documents
____Other (Specify eg. Verizon, Cox, Attorney)

_____

Purpose of use or disclosure of information (for example: Medical Care, Legal, Insurance, Personal, Individual's request, etc. Must be specific. _____

I understand that I have a right to revoke the authorization at any time. If I revoke this authorization, I must do so in writing and present it to the person/facility/agency that was authorized to release the information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the above information is disclosed, the recipient may re-disclose it and the information may not be protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary and that this authorization to release my information is considered active while S.N.E.S.A.A. remains my Representative Payee. I understand that I do not need to sign this form to continue to receive Representative Payee services from S.N.E.S.A.A.

_____ Date_____
Beneficiary/Guardian Signature

_____ Date_____
Witness Signature