DHS-25
Rev. 05/03

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

LTSS Fax # 415-8422

AUTHORIZATION TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION

This form is not intended to be used as a Medical Release form.
Please **do not** include any Medical information on this form.

I hereby authorize the Rhode Island Department of Human Services to obtain from, or release to:

Name _____
Person, Agency, or Organization

Address _____

the following information pertinent either to me or to the person listed below for whom I am responsible:

Financial _____
(Specify) (Dates)

Social _____
(Specify) (Dates)

Other _____
(Specify) (Dates)

Name (printed) _____
Person about whom information is requested

Date of Birth_____ **Social Security Number**_____**VA Claim Number**_____

Address _____

Reason for Request _____

I understand that records are protected under the General Laws of Rhode Island and cannot be disclosed without written consent, except as otherwise specifically provided by the law. Any information released or received as a result of this consent shall not be further relayed in any way to any person, or organization outside of the department, without an additional written consent from me, unless it is for the purpose of processing my application for assistance or services. This consent is voided at the termination of assistance or withdrawal from services or can be terminated at any time.

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Signature of Client, Parent, or Guardian Relationship to above Date

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Name (printed) _____
DHS Agency Representative Title

District Office Address _____