

**FLORIDA STATE HOPWA PROGRAM
CONSENT TO RELEASE INFORMATION**

I, _____, authorize staff and/or volunteer staff of the following agencies to release and/or share information regarding services received, past, current, or in the future, for the express purpose of receiving or gaining access to services related to my current or future needs.

This consent may be revoked by me anytime by writing and informing the agency holding this original form. I understand that I may add other agencies to this list if needed.

Agency	Client Initials	Date
Lead Agency (Heart of Florida United Way)		
Department of Health (Required)		
Department of Children and Families		
Food Stamp Office		
Medicaid Office		
Social Security Office		
Primary Healthcare Provider		
Other:		

Client/Guardian Signature

Date

Housing Coordinator Signature

Date