The Arc Oregon

AUTHORIZATION TO RELEASE INFORMATION

Mail ORIGINAL completed form to:
THE ARC OREGON, 2405 FRONT STREET NE, SUITE 120, SALEM OR 97301

Client Name:			
Account Number:		Date of Birth:	
Address:			
City, State, Zip:			

Regarding the above named person, I authorize The Arc Oregon to

☐ Receive information and/or ☐ Release information to and/or from:

Name:			
Organization:			
Relationship to Client:			
Address:			
City, State, Zip:			
Phone:		Cell Phone:	

For the purpose of participating in the Oregon Special Needs Trust (OSNT) Program, I agree to the release of information to and from The Arc Oregon as follows:

☐ OSNT Sub-Trust Account Financial Information

☐ Individual Service Delivery and Public Assistance Information

☐ Other: _____

I understand that I may cancel this consent upon written notice at any time, except to the extent that action has been taken based upon this consent before cancellation. Records obtained as authorized by this consent will be maintained in accordance with state and federal confidentiality regulations which prohibit redisclosure without written consent. This authorization will expire one year from the date signed below.

_____ _____
Signature of Authorized Person Date

_____
If the above Signature is NOT that of the Client, print name and describe authority to represent.