

**RENTAL ASSISTANCE: PERMANENT SUPPORTIVE HOUSING  
RELEASE OF INFORMATION**

Date: \_\_\_\_\_

**Client Name:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

In accordance with Federal Regulation Code 42, Part 2, I hereby authorize the following entity(ies) to release/disclose any and all past, present and future information and records to facilitate my request and receipt of services and assistance:

- |   |  |
|---|--|
| <input type="checkbox"/> New Horizons of the Treasure Coast       | <input type="checkbox"/> Legacy Behavioral Health            |
| <input type="checkbox"/> Treasure Coast Homeless Services Council | <input type="checkbox"/> Department of Children and Families |
| <input type="checkbox"/> Martin County Health & Human Services    | <input type="checkbox"/> Social Security                     |
| <input type="checkbox"/> St. Lucie County Community Services      | <input type="checkbox"/> Other: _____                        |
| <input type="checkbox"/> Ryan White Services                      | <input type="checkbox"/> Other: _____                        |

Including the following information: patient records related to any attempted suicide, emotional illness, psychological services records, if any; social services records, if any; communications made by me to a social worker, counselor, psychologist, physician, or other health care provider; and information regulated by Federal Public Law 93-282 (confidentiality of alcohol and drug abuse patients and records documenting the diagnosis and/or treatment of communicable diseases and/or serious disease and infections as defined by the US Department of Health and Human Services rules which include venereal disease, tuberculosis, AIDS, ARC, HIV status and other related diseases, if any).

- Financial Information
- Housing Requirements
- Physical/Mental Health Diagnoses and related limitations, including mobility, employment, etc.
- Other: \_\_\_\_\_

for services covering the dates from \_\_\_\_\_ to \_\_\_\_\_ for the specific purpose of obtaining stable housing, ensuring my ongoing eligibility and accessing other programs.

I release the above cited individuals or facilities of any legal liability that may arise from the release of the information requested. I understand that the agency cannot release information obtained from other sources. I understand that the individual/institution/agency receiving this information may not re-release it to any other individual, institution, or agency. I also understand that this authorization for release of information will expire on \_\_\_\_\_ unless indicated below:

(Not to exceed 1 year)

Condition date or event of earlier expiration \_\_\_\_\_

I also understand that this release can be revoked, by me at any time and that the revocation must be signed and dated by me, and that the revoking of the release will not affect information released prior to the revoking of the release.

\_\_\_\_\_  
Head of Household Signature                      Date                      Relationship (if minor)

\_\_\_\_\_  
Spouse/Significant other                      Date

\_\_\_\_\_  
Witness Name (print)                      Witness Signature                      Date

**\*\* I hereby revoke my consent for the release of the previously stated information\*\***

\_\_\_\_\_  
Signature                      Date                      Relationship (if minor)