WORKFORCE SOLUTIONS
GOLDEN CRESCENT

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ SSN: _____,
hereby authorize the release of and/or exchange of information including the review of copies of all medical, vocational, and other related records and to discuss pertinent information with other professionals involved in my employment planning. I further authorize Texas Workforce Commission, United States Social Security Administration, Texas Department of Assistive and Rehabilitative Services (DARS) Division for Rehabilitative Services, DARS Blind Services, DARS Early Childhood Intervention Services, DARS Disability Determination Services, Selective Service, Texas Health and Human Services Commission, Gulf Bend MHMR, Treatment Associates, Office of the Attorney General or other related programs/institutions to release information which may assist me in obtaining services.

I also authorize any employer(s) to release information regarding my past, present or future employment records including wage/benefit amounts and dates of employment.

This AUTHORIZATION FOR RELEASE OF INFORMATION form shall be valid from the date of signature to one year after I leave any of the Workforce Solutions Golden Crescent services.

_____ _____
Applicant Signature
If applicant is younger than 18 years old, signature of parent/guardian required

_____
Address

_____
City State Zip Code

_____
Date

_____
Workforce Solutions Golden Crescent Staff Signature
CK 04/05/10