



Voluntary Authorization to Release Information

Release for Designated Organization, Employer or Individual

I hereby authorize
to release the information as requested below to the Department of Transitional Assistance.

Recipient Release

I hereby authorize the Department of Transitional Assistance (DTA) to contact the organization,
employer or individual designated above regarding **SELECT**

(Any information released will be kept confidential.)

Explain:

Applicant/Recipient

Date

Signature

Social Security Number (Optional)

Address

City/Town

ZIP

AU Manager Name

AU Manager Signature

Date

TAO Name Address

City/Town

ZIP

AU Manager Telephone Number

Fax Number

Voluntary Authorization to Release Information is valid for 90 days from the date of the applicant/recipient signature.