AUTHORIZATION FOR RELEASE OF PUBLIC ASSISTANCE INFORMATION
(NOT AUTHORIZED TO RELEASE MEDICAID INFORMATION WITH THIS FORM)

I, _____, authorize the release of information regarding my dates of application, benefits received, payments on my or my dependents' behalf to me or to third parties, or other (see below) to be released to the undersigned or their authorized representatives:

NAME OF ATTORNEY OR REPRESENTATIVE_____
Or check here if it is for yourself __
ADDRESS: _____
CONTACT PHONE: _____

from the state or local agencies overseen by the New York State Office of Temporary and Disability Assistance, for the purpose of verifying my eligibility status. I understand that no other person or party other than the following people or parties will be provided with this information without my approval.

I also understand that there will be a charge for any records copied and delivered to me over 25 pages in total, in the amount of $0.25 per page, which must be paid prior to release of my records.

This authorization will expire one (1) year from the date of this authorization, or a specified date or event: _____, or whenever I provide notice that I am revoking this authorization to a DSS-ES supervisor in the unit from which I am receiving benefits (SNAP, TA, Child Care Program, HEAP, etc.).

_____ _____
Name (Print) Please print any other surname by which you are or have been known.

_____ _____ _____
Signature Date Social Security No.

Sworn to before me this
day of _____, 20__.

_____
Notary Public