



**Economic
Opportunity
Program, Inc.**

Strengthening the fabric of our community

**Economic Opportunity Program, Inc.
Family Support Services
Release for Information Exchange**

I, _____, do hereby:

- 1.) Authorize **all medical providers, educational institutions, social agencies, and any other relevant individual, corporation or community resource** to release any medical, education, social or other relevant information **regarding myself (and my children)** to the OPWDD/Family Support Services.
- 2.) Authorize the OPWDD/Family Support Services of EOP, Inc. to release any such information to medical, educational, social and any other relevant community resource personnel.
- 3.) Authorize the **Family Support Services to release** confidential information from my file concerning myself or my family **to any agency or community resource (public or private)**, having a justifiable need for information in order to more effectively render help, aid or counseling; **any such public or private community resource agency shall release confidential information to the OPWDD/Family Support Services.**
- 4.) Authorize the OPWDD/Family Support Services to release confidential information from my file concerning me or my family to any legal representative, law guardian or Family Court.
- 5.) Authorize the release of my basic information and names of programs I participate in at EOP, Inc. to be included in an Economic Opportunity Program, Inc. computerized database. This information will be used for reporting purposes only to funding sources of E.O.P. programs. At no time will my identity be revealed in these reports.

Regarding Names: _____ DOB _____

_____ DOB _____

This permission is valid for as long as I am enrolled in the OPWDD/Family Support Program, unless otherwise indicated.

Dated: _____

Signature

Witness