

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of information requested by the Department of Health & Social Services or its agents within the Department of Law. The requested information will only be used in the administration of public assistance programs, and will not be released to any other person or agency outside of the Department of Health & Social Services or its agents within the Department of Law. This release of information will be in effect while I am an applicant or recipient of public assistance, and for any later investigations of my eligibility and receipt of benefits.

Persons or organizations that may be contacted include, but are not limited to: the Department of Law, the Department of Public Safety, the Department of Fish and Game, the Department of Labor, the Department of Military & Veterans Affairs, the Department of Revenue, the Bureau of Citizenship and Immigration Services, Alaska Housing Finance Corporation, Social Security Administration, local governments, public assistance program contractors and grantees, tax assessors, financial institutions, Native corporations, stock brokerage firms, landlords, employers, school authorities, and private individuals.

A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL.

Your Signature

Signature of Other Adult Household Member

Printed Name

Printed Name

Social Security Number

Social Security Number

Address

Address

Phone Number

Phone Number

Date

Date