Alameda County Social Services Agency

SSI ADVOCACY CONSENT FORM

Authorization to Disclose Confidential Information

CLIENT INFORMATION:

Name: _____ Case Number: _____

Address: _____ Phone Number: _____

City/State/Zip: _____ Message Number: _____

Email: _____ ◉ CalWORKs ○ General Assistance

I HEREBY AUTHORIZE:

Alameda County Social Services Agency:

Social Worker: _____ **Worker Number:** _____ **Date:** _____

To release following confidential information:

☐ CW 61/61A Authorization / Physical Capacities
☐ CW 61/61B Authorization / Mental Capacities
☐ 90-2 Medical Report
☐ 90-2MH Mental Health Clinician's Confidential Report
☐ SSA 827 Authorization to Disclose Information to the Social Security Administration
☐ Other _____

To one of the following organizations:

Homeless Action Center ◆(510) 540-0878 3126 Shattuck Ave. ◆Berkeley, California 94705	**Homeless Action Center** ◆(510) 695-2260 2601 San Pablo Ave. ◆Oakland, California 94612
TRUST Clinic ◆ (510) 210-5050 386 14th Street ◆Oakland, California 94612	**Bay Area Legal Aid** ◆ (510) 663-4744 1735 Telegraph Avenue ◆Oakland, California 94612

I understand that the purpose of releasing my confidential information is to assist me with SSI advocacy.

Signature of Client, Parent, or Guardian **Relationship** **Date**

EXPIRATION: This Authorization expires twelve (12) months from the date signed or on: _____

REVOCATION: This authorization may be revoked at any time unless prior action has been taken as a result of this form.

WARNING: PROHIBITIONS ON USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION, except as required by State or Federal laws, use of information released for other than the stated purpose, or re-disclosure or transfer of this information to any person or entity not named herein is PROHIBITED. An additional written authorization must be obtained for any proposed new use of the information or for its re-disclosure or transfer of such information.