South Puget Intertribal Planning Agency

Workforce Development Programs

Release of Information

Name:	SSN:	DOB:

For Office Use Only	
Please send requested information to:	
SPIPA/WFD Programs:	Email:
Address:	
Phone:	Fax:

AUTHORIZATION

I authorize to be disclosed to the South Puget Intertribal Planning Agency all of the following information, as specified, which may be contained in my records. This will include but not be limited to childcare, education, medical, tribal, state, and federal benefits.

I understand this information will be used to determine eligibility and coordinate services with

- ☐ **Tribal, State and Federal Benefits**
- ☐ **Childcare**
- ☐ **Education**
- ☐ **Medical**
- ☐ **Other Information: _____**

I understand that I may cancel this authority at any time unless action has already been taken. Unless cancelled, this authorization will expire 1 year from the signature date or specified expiration date below.

_____	_____	_____
Client Signature	Date	Expiration Date
_____	_____	_____
Parent/Guardian Signature (if applicable)	Date	Expiration Date