AUTHORIZATION TO RELEASE CASE INFORMATION
Human Resources Administration (HRA)
Office of Constituent Services
Phone – (212) 331-4640 Fax – (212) 437-2615

The purpose of this document is to provide the Human Resources Administration with verification of a client's consent before releasing case information to a third party. Please note that this document should **NOT** be used for the purpose of obtaining any health related case information on programs or issues such as Medicaid, HASA, mental illness and/or substance abuse issues. For those types of cases, please use the HIPAA Authorization Form.

Client's Name _____

Client's Date of Birth _____

Case Number _____

Client's Address _____

Client's Phone Number _____

Describe Issue and Request _____

_____

Time Period for Information being requested

Please have the Client read and sign the below portion.

I, or my authorized representative, request that my HRA case information be released to the below elected official, non-profit agency or community based organization for the purpose of assisting me with my case-related issues.

_____ _____

Name of Requestor and Office Affiliation Contact Number

_____ _____

Signature of HRA Client Date: (valid for 90 days)

Revised May 2015