



Venaglia Payee, Inc.
PO Box 80841
Portland, OR 97280

Consent to Release of Information for the purpose of Representative Payee Authorization

Client Name: _____
(First) (Middle) (Last)

Social Security Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____
(m) (d) (year)

With my signature below, I _____ hereby authorize Venaglia Payee, Inc. to file an application with the Social Security Administration to become Representative Payee for any SSA/SSI benefits I may be eligible to receive. I understand that these benefits will be administered by Venaglia Payee, Inc. I authorize Venaglia Payee, Inc. to disclose and receive information about me for use in managing my benefits and payment of my bills. Venaglia Payee, Inc. has my consent to speak with any vendors/creditors necessary when acting on my behalf to pay my bills, make payment arrangements, or add/change/terminate my services. This authorization will remain in effect for the duration of the time for which Venaglia Payee, Inc. is my Representative Payee.

Client Signature: _____ Date: _____ / _____ / _____
(m) (d) (year)
