Full Circle Employment Solutions LLC

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: John Doe

SSN: 123-45-6789 **D.O.B.: 05/01/1987**

I have requested services from Full Circle Employment Solutions for the purposes of benefits planning. I do hereby authorize the following agencies to release information or records, verbally or in writing, about me to Full Circle and I authorize Full Circle to share detailed benefits information with the following agencies:

Full Circle Employment Solutions
P.O. Box 7030
Hyattsville, MD 20787

1-888-466-2942 (voice)
1-888-466-2940 (fax)

☒ State Social Services Agency: MD DRS
☐ State Vocational Rehabilitation Agency:
☐ Housing & Urban Development Authority:
☐ Ticket to Work program:
☐ Other:
☐ Other:

Verification of the following benefits:

☐ SNAP $_____
☒ Medicaid- Type or Code _____
☒ Medicaid Waiver- Type _____
☐ Medicare Savings Program: ☐ QMB ☐ SLMB ☐ QI
☐ Housing Assistance _____
☐ TANF/TCA $_____
☐ Childcare Subsidy $_____
☐ Other: _____

I am the individual to whom the information or records applies too or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from records, I could be fined, imprisoned or both.

Signature Date

Signature of parent or guardian (if applicable) Date

These authorizations are valid for one year (or until case termination) from the date of signing and may be revoked at any time in writing.