Alliance Center for Independence

A Center for Independent Living serving Somerset, Middlesex & Union Counties

Authorization for Release of Information

I, _____ Date of Birth _____ currently living at _____
_____ (____)_____-_____

Authorize the **Alliance Center for Independence (ACI)** to release the following confidential information:

(Be specific about the information you are releasing)

_____
_____
_____
_____

To: Name of Individual or Agency _____
Address _____
_____
Telephone (____)_____-_____

This consent is to be effective from _____ (date) to _____(date).
(Not to exceed 30 days)

READ CAREFULLY: I understand that my records are confidential. I understand that by signing this authorization I am allowing the release of my information to the agency or person specified above. I understand that my records may contain information regarding my disability (disabilities). I understand that ACI will not release records which were received from another provider. I also understand that I may revoke this authorization at any time by written except to the extent that action has already been taken.

I have read the above and foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent.

Date:_____ Signature:_____

629 Amboy Ave ● Edison, NJ 08837
Phone: 732.738.4388 Fax: 732.738.4416 TTY: 732.738.9644

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