Idaho State Family Programs Office

4250 Cessna St.
Gowen Field Bldg. 270
Boise, Idaho 83705

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORAMTION
Privacy Act Statement

Authority: 10 U.S.C. 8013 and Executive Order 9397
Principal Purpose: Client demographics are required for accurate service delivery, analysis and future program planning.
Routine Uses: This information may be disclosed to Federal, State, local or foreign law enforcement authorities for investigating or prosecuting a violation or potential violation of law; to Federal State, or local agencies to obtain information concerning hiring or retention of an employee, issuance of other benefit; to congressional office in response to their inquiry made at the request of the individual; to the Office of Management and Budget in connection with review of private relief legislation as set forth in OMB Circular A-19; to NARA for records management inspections; and to the Department of Justice for pending or potential litigation.
Disclosure is Voluntary: Failure to provide the necessary date will make it difficult to provide complete services

This form cannot be used for the re-release of confidential information provided to the Idaho National Guard Family Programs office by other individuals or agencies. Such requests should be referred to the original individual or agency.

Please place initials to the left of each item being approved.

I, _____, authorize the Idaho National Guard Family Programs to:

_____ Release to: _____
_____ Obtain from: _____
_____ Exchange with: _____

The following specific information pertaining to myself:

_____
_____

For the purpose of: (optional if no purpose is stated, all lawful purposes are assumed).

_____ Evaluation/assessment and/or coordinating treatment efforts
_____ Providing resources and services
_____ Other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____

Read before signing:
I understand that the information which I have authorized to be disclosed will be used for the purpose(s) stated. I acknowledge that it is my responsibility to be aware of any rights of confidentiality which I may have regarding the information which I am releasing and that by signing this consent I am waiving my rights, if any, to confidentiality for purposes which I have approved.
I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____ OR _____
Signature of Client Date Last Four SSN Date of Birth

_____
Signature of Witness Date