



Klamath & Lake Community Action Services
 2316 S 6th St. Suite C Klamath Falls OR 97601
 (541) 882-3500 Fax (541) 882-3674
www.klcas.org

To Our Applicants: We can help you better if we are able to work with other agencies that know you and your family. By signing this form, you are giving permission for these organizations to share information about your situation.

Your Name and Date of Birth: _____

Purpose: The information received will be used to evaluate my situation and to plan for and coordinate services for my family for other purposes as specified: Homeless Prevention Assistance
 I authorize any of the following individuals or agencies that I have initialed below to share and exchange information about me or my family and my circumstances with one another for the purpose described above:

<p><u>ENTIRE FIRST COLUMN Recommended as appropriate</u></p> <p>Initial:</p> <p>_____ KLCAS: Homeless Prevention, Family Support & Connections, Energy Assistance, and Representative Payee.</p> <p>_____ State of Oregon, Department of Human Services: Self-Sufficiency, Seniors & People with Disabilities, Vocational Rehabilitation, Child Welfare.</p> <p>_____ Klamath/Lake: Early Childhood Intervention, Klamath Family Head Start, Healthy Families America, OCDC, school district.</p> <p>_____ Klamath Tribal</p> <p>_____ Landlord</p> <p>_____ Klamath Housing Authority</p> <p>_____ Social Security Administration</p> <p>_____ Dept. of Veteran's Affairs</p> <p>_____ IRS</p> <p>_____ Reach</p> <p>_____ Mentor Oregon</p> <p>_____ Connections DBA SORB Services</p> <p>_____ Developmental Disability Services</p> <p>_____ Spokes</p>	<p>Initial:</p> <p>_____ Dept. of Justice (Child Support)</p> <p>_____ Legal Aid Services of Oregon</p> <p>_____ Klamath Works</p> <p>_____ OHCS</p> <p>_____ Oregon Employment Department</p> <p>_____ SOCO Development</p> <p>_____ Klamath Adult Learning Center</p> <p>_____ Goodwill</p> <p>_____ WIC</p> <p>_____ Hope Pregnancy Center</p> <p>_____ Klamath Tribal Health</p> <p>_____ Transformations Wellness Center</p> <p>_____ Lake County Crisis Center</p> <p>_____ UCAN</p> <p>_____ Sky Lakes Outpatient</p> <p>_____ Cascade Health Alliance</p> <p>_____ Drug Court-State of Oregon</p> <p>_____ Klamath Basin Behavioral Health</p> <p>_____ Dragonfly Transformations</p> <p>_____ Best Care Treatment Services</p> <p>_____ Lutheran Community Services</p> <p>_____ Translink(Medical Bus)</p> <p>_____ Medical Provider : _____</p> <p>_____ Dental Provider : _____</p> <p>_____ Child Care Provider: _____</p> <p>_____ Other: _____</p> <p>_____ Other : _____</p>	<p>Initial:</p> <p>_____ Police Department</p> <p>_____ County Sheriff Department</p> <p>_____ Parole and Probation</p> <p>_____ Thrive Church</p> <p>_____ St. Vincent de Paul</p> <p>_____ Gospel Mission</p> <p>_____ Klamath Advocacy Center</p> <p>_____ Employer/Potential Employers</p> <p>_____ Other: _____</p> <p>Initial: Utility Companies</p> <p>_____ Avista</p> <p>_____ Pacific Power</p> <p>_____ Spectrum Cable</p> <p>_____ Dish</p> <p>_____ Direct TV</p> <p>_____ Sprint</p> <p>_____ US Cellular</p> <p>_____ City Water</p> <p>_____ Sprint</p> <p>_____ Waste Management</p> <p>_____ Other: _____</p> <p>_____ Other: _____</p> <p>_____ Other: _____</p> <p>_____ Other: _____</p>
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This permission is valid for 18 months from the date of the signature.

I can cancel this at any time; I must do so in writing. I understand that the cancellation will not affect any information that was already released before cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve of the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

_____ Parent _____ Guardian _____ Legal Custodian
 Signature Date

_____ Date
 KLCAS Team Member Signature

To those receiving information under this authorization: State and Federal laws protect the information disclosed to you. You are not authorized to release it to any agency or person not listed on this form without the specific written consent of the person to whom it pertains, unless authorized by other laws.

This is a true copy of the original authorization document _____
 (Agency Staff) Date

