Disaster Case Management

DR #_____ – Iowa _____

Release of Confidential Information Form

I, voluntarily authorize the exchange of information for the coordination of disaster recovery services and case management.

Name of Client: _____

Mailing Address: _____

City, State, ZIP: _____

Phone/Contact Number: _____

Date of Birth: _____

I allow information to be exchanged between the following agencies/organizations:

Name of Community Action Agency:		
Name of Local Long Term Recovery Committee:		
Name of COG/Iowans Helping Iowans Program:		
Name of Local Agency on Aging:		
Name of Local United Way:		
Iowa Community Action Association	Iowa Department of Human Services	Iowa Department of Human Rights
Red Cross	Salvation Army	Iowa Works
List OTHER ORGANIZATIONS		

This authorization becomes invalid on this date or when the case is closed: _____
(not to exceed one year)

Client's and/or Guardian's Signature **Date**

Witness/Worker Signature **Date**