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|  | MISSOURI DEPARTMENT OF SOCIAL SERVICESFAMILY SUPPORT DIVISION**AUTHORIZATION FOR RELEASE OF INFORMATION** |
| **FROM** |  FAMILY SUPPORT DIVISION     | TELEPHONE NUMBER     -     -      |  | DATE3/24/2022 |
|  |  | OFFICE ADDRESS      |  |
|  |  |       |  |
|  |  |       |  |
| **TO** | NAME      |  |
|  | ADDRESS (NUMBER AND STREET)      |  |
|  | CITY STATE ZIP CODE      |  |
| **RE** | CASE NAME      | CASE NUMBER      |
|  |
| **I authorize the release of information regarding my situation described below to representatives of the Missouri Family Support Division.**           |
| **INFORMATION SHALL BE RELEASED BY**                     |
| **I (we) hereby release any person, firm, physician, clinic, or hospital from any liability for information furnished pursuant to this authorization.** |
| APPLICANT/PARTICIPANT SIGNATURE | DATE |
| SIGNATURE OF SPOUSE | DATE |
| SIGNATURE OF OTHER | DATE |
| ADDRESS (STREET, CITY, STATE, ZIP CODE)      |
| MO 886-0683 (01-2014) | **PERMANENT** IM-6 (01-2014) |