Consent to Release Non-Medical Personal/ Confidential Information

Society for the Blind
2750 24th Street Sacramento, CA 95818

Applicant/Client's Full Name: ____

Social Security Number: ______________________ Date of Birth: ________________________

Street Address: ____

City, State, Zip: ____

I Hereby Consent to and Authorize Society for the Blind to: (check one)
_____ Obtain from you the following information:
_____ Release to you the following information:

Description of Information to be Released: ____
____
____

I understand that I have a right to receive a copy of this signed authorization. I understand that this consent shall be valid for a period not to exceed 1 year, unless otherwise specified* from the date this consent is signed. (*Specified date, if other than 1 year: ________________)

Send information to:
Name: ____

Address: ____

Applicant/Client's Signature: ___________________________________Date: ________________

Parent/Guardian Signature (Required for Minor): ______________________________________

If unable to write his/her name, the client should enter an "X" or other mark. Signatures of 2 witnesses are required.

Witness 1: ____ Date: _____________________

Witness 2: ____ Date: _____________________

Please return this completed form to designated Society for the Blind staff.

Copy 1 – Addressee   Copy 2 – Case File   Copy 3 – Client