Zero Hour Life Center
Recovery Community Organization
The time for change is..NOW!

Authorization to Release/Disclose Information

NAME:

DOB: **SSN:**

I _____ hereby grant permission to Zero Hour Life Center Inc to release or disclose any and all information regarding my claim for Social Security Insurance (SSI) and Social Security Disability Income (SSDI) benefits to individuals or organizations who are either able to provide helpful information or evidence to support my claim, or provide resources and assistance to promote a coordinated system of care.

I acknowledge that I have the right to specifically name persons or organizations for which I do not want my personal information shared with.

I have the right to revoke this authorization to release information at any time. Upon choosing to revoke this right, I must immediately notify Zero Hour Life Center Inc in writing.

I hereby exclude from this release information to the below listed individuals or organizations:

NAME/ORGANIZATION	RELATIONSHIP

Effective from_____ to _____

Claimant's Printed Name

Claimant's Signature Date

Care Coordination/Soar Case Worker Signature Date

PHONE: (352)765-4943 | FAX: (352)388-1921
EMAIL: RECOVERY@ZEROHOURLIFECENTER.ORG | WEBSITE: WWW.ZEROHOURLIFECENTER.ORG