

Deaf and Hard of Hearing Service Center
Consent for Release of Personal/Confidential Information

<input type="checkbox"/> Fresno Office 5340 N. Fresno Street Fresno, CA 93710 Voice (559) 225-3323 VP (559) 578-4117 FAX (559) 225-0116	<input type="checkbox"/> Merced Office 855 W. 18th Street, Suite A Merced, CA 95340 Voice/VP: (209) 230-9910 FAX (209) 726-3780	<input type="checkbox"/> Central Coast Office 36 Quail Run Circle, Ste 100-T Salinas, CA 93901 Voice (831) 753-6540 FAX (831) 753-6542	<input type="checkbox"/> South Valley Office 113 N. Church Street, Suite 222 Visalia, CA 93291 Voice/VP: 559-302-9979 FAX (559) 559-225-0116
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Client's Full Name: _____

Other Identifying Information: _____

Address: _____ **Phone:** _____

_____ **Email:** _____

From: DHHSC - Service Provider(s):

1. _____ **Direct Phone or E-mail:** _____

2. _____ **Direct Phone or E-mail:** _____

3. _____ **Direct Phone or E-mail:** _____

To: Name of Contact Person: _____

Agency/ Relationship: _____

Address: _____ **Phone:** _____

_____ **E-mail:** _____

I hereby give consent to and authorize DHHSC to:

_____ **Release the following information**

_____ **Obtain the following information**

Vocational Assessment

Employment History

Educational Records

Social Security Records

Medical Reports

Counseling Reports

Psychiatric Reports

Welfare Case

Photo/Article

Other: _____ **Other** _____

Additional Information: _____

Date Begin: _____ **Date Ending:** _____

Client/Guardian Signature: _____ **Date:** _____

DHHSC Staff Person: _____ **Date:** _____