



## Authorization for the Department to Release Information

My Name:
My Social Security Number:

**I authorize the Department to disclose information to:**

Name of person or organization to receive information:	Telephone Number:
Fax Number:	Email Address:

**Release information on the following cases (choose one):**

- ☐ All my Child Support Services (CSS) cases  
☐ These specific CSS case(s): \_\_\_\_\_  
☐ Other \_\_\_\_\_

**Information that can be released:**

- ☐ All information that CSS can legally disclose  
☐ Payment History   ☐ All   ☐ Specific Dates \_\_\_\_\_ to \_\_\_\_\_  
☐ Balance  
☐ Other (please specify) \_\_\_\_\_

**This authorization expires (choose one):**

- ☐ This is a one-time authorization  
☐ Upon my request or when the case is closed  
☐ On this date \_\_\_\_\_.

This form gives the Iowa Department of Health and Human Services authorization to release information you specify to a specific party or organization. You may revoke this authorization at any time. If an expiration date is not chosen, this release will be considered a one-time authorization.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date