IOWA | Health and Human Services

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