Release of Information

NAME:_____ TELEPHONE #_____

CLIENT NUMBER:_____

ADDRESS: _____

CITY, STATE, ZIPCODE : _____

EMAIL ADDRESS:_____

PROGRAM: PUBLICHOUSING : SECTION 8:_____AREYOU **AN APPLICANT**? ☐ YES ☐ NO

- REQUIRED INFORMATION: The following member of my household has a disability, i.e., a physical or mental impairment that substantially limits one or more life activities.

  Name:_____Date of Birth:_____

  Relationship or association with you: _____

- (If applicable) I authorize HHA to contact the following individual who assisted me in the completion of this form:

  Name:_____Telephone:_____

  Address:_____

  City, State, Zip Code: _____

  Email address:_____

- **REQUIRED INFORMATION**: I authorize HHA to verify that I or member of my household has a disability and need the accommodation I have requested. In order to verify this information, HHA may contact the following knowledgeable third-party:

  Name:_____

  Title of Third - Party:_____

  Agency, Facility or Institution (if any):_____

  Address:_____

  City, State, Zip Code:_____ Telephone:_____Fax: (required)_____

  Email address:_____

This form will only be used on an as-needed basis to gather information in relation to your request

I authorize the above third-party to release any information to assess my request for reasonable accommodation. By signing I am also acknowledging that I understand that the HHA will only ask for information that is necessary regarding my request for accommodation.

Signature: _____ Date:_____