



KAW NATION SOCIAL SERVICES

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RELEASE OF INFORMATION

I, _____, grant and authorize the exchange of information between the Kaw Nation Social Services Department and the following agencies/programs:

- | | |
|--------------------------------------|---|
| Tribal/State Employment Office | Tribal/State Drug and Alcohol Programs |
| Tribal State Social Service Programs | Tribal/State Housing Programs |
| Social Security Administration | Veteran's Administration |
| Tribal/State Education Programs | Tribal/State Federal Probation Programs |
| Tribal/State/Federal Courts | Tribal/State Child Protection Services |
| Tribal/State Medical Services | Tribal/State Mental Health Services |
| Tribal Enterprises | Tribal/State Voc-Rehab Programs |
| Alaska Native Corporations | Indian Health Services |
| State/County Fiduciary Trust Offices | Other: _____ |

Any information exchanged will pertain to my eligibility to receive benefits or referrals to other Human Services/Social Services/Financial Services programs that would benefit me. By signing this release of information form, I agree and understand any information obtained will be kept confidential and will be used only for the purposes directly connected with providing benefits or services on my behalf. I further agree and understand that any information obtained may be released to proper governmental agency, court, or law enforcement agencies for purposes of legal and investigative action concerning fraud.

This Release of Information will remain in effect for one (1) year from date of signature or until I request in writing to rescind said authorization.

Signature of Applicant

Date