Community Fund Management Foundation

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Where Quality of Life Matters

Authorization to Release Information

(Return completed form to address or fax number above)

I. I am authorizing CFMF to disclose the following information:

_____ Any information that could be provided to the Designated Advocate, such as a copy of the Joinder Application, account balance, and tax information

_____ Other: _____

_____

II. To the person or agencies identified below:

_____ Department of Medicaid or DJFS

_____ Social Security Administration

_____ Attorney

_____ County Board of DD

_____ Other: _____

Contact Name _____

Business Name _____

Address _____

City, State, Zip _____

Phone Number _____

Email Address _____

Fax Number _____

III. This Authorization will expire:

_____ When CFMF receives my written revocation of this Authorization

_____ Date: _____

_____ _____
Date Signature of Currently Acting Designated Advocate

_____
Printed Name of Currently Acting Designated Advocate

Beneficiary Name _____

Agreement No. _____
(Please include the letter(s) and 8 digit number)