NH Department of Health & Human Services (DHHS)
Division of Family Assistance (DFA)

DFA Form 11
08/12 rev.9/15

Authorization to Release Information

Printed Name of Person to Whom the Release of Information Pertains

Case #, RID #, or MID #, if known

I hereby authorize and request:

Name and Address of Individual or Agency Providing the Information:

NH DHHS-All Programs and Divisions

to provide the following information: Case Detailed Information

to:

Name and Address of Individual or Agency Receiving the Information:

Town of Conway General Assistance Office
BJ Parker and staff appointed to act in her absence
1634 East Main Street
Center Conway, NH 03813

I grant my permission for the reproduction of the above information to be given to the individual or agency named. Release of confidential information is subject to State and Federal laws. By signing this release, I acknowledge my permission to release the specified information to the individual/agency I have named. **This authorization expires 12-months from the date this form is signed.**

Information released cannot be re-released by the receiving individual/agency without additional authorization.

(Signature)

(Date)

(Printed Name)

If the signature above is not that of the person to whom the information pertains, the relationship of the signer to that person must be indicated. In addition, the signature must be witnessed.

(Relationship)

(Witness)

(Date)