MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

AUTHORIZATION FOR RELEASE OF INFORMATION

FROM	FAMILY SUPPORT DIVISION	TELEPHONE NUMBER - -	DATE
	OFFICE ADDRESS		
TO	NAME		
	ADDRESS (NUMBER AND STREET)		
	CITY STATE ZIP CODE		
RE	CASE NAME	CASE NUMBER	

I authorize the release of information regarding my situation described below to representatives of the Missouri Family Support Division.

INFORMATION SHALL BE RELEASED BY

I (we) hereby release any person, firm, physician, clinic, or hospital from any liability for information furnished pursuant to this authorization.

APPLICANT/PARTICIPANT SIGNATURE	DATE
SIGNATURE OF SPOUSE	DATE
SIGNATURE OF OTHER	DATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)	