

Commonwealth of Massachusetts
Massachusetts Department of Transitional Assistance

Voluntary Consent to Release Information

Section 1: DTA Client or Applicant	
_____ Client/Applicant Name	
_____ DTA Agency ID or Last Four Digits of SSN	_____ Date of Birth
Section 2: Information to be Shared	
I give permission to DTA to share all confidential information about my public assistance cases with the person or organization named in Section 3.	
Section 3: Person or Organization to Receive the Information	
_____ Name of Person or Organization	_____ Phone Number
_____ Address of Person or Organization	
Section 4: Right to Revoke	
You may change your mind and stop the release of this information. To stop it, you must: <ul style="list-style-type: none">• call 1-877-382-2363 during regular business hours and speak to a DTA Representative; or• write to DTA. Send your request to the address or fax number listed below.	
Section 5: Signature	
I understand that when I sign below, I am giving permission to DTA to share my confidential information.	
_____ Client/Applicant Signature	_____ Date

This Voluntary Consent to Release Information is **valid for one year** from the date of the applicant/client signature, unless revoked (see Section 4).

Mail or fax this form to: **DTA DOCUMENT PROCESSING CENTER, P.O. BOX 4406, TAUNTON, MA 02780-0420. FAX: 617-887-8765**

VARI-OI (12/2014)