Disclosure and Release of Information Authorization

I do hereby authorize a disclosure of information and records concerning myself, by and to an agent of the Sherburne County Attorney's Office for the limited purpose of verifying receipt of County Assistance for my family. There shall be no release of any information regarding financial or other information, other than current eligibility.

I am willing that a photocopy of this Authorization be accepted with the same authority as the original for a period of 90 days from the date of the last signature.

Date **Signature**

Please Print Clearly

Signer's Last Name **First Name** **Middle Name**

Child's Last Name **First Name** **Middle Name**

Street Address **City** **State** **Zip**

Type of Assistance Received

Name of Financial Worker