Early Learning Coalition of Alachua County

4424 NW 13th Street A5
Gainesville FL 32609
352-375-4110
fax 352-375-4131

AUTHORIZATION TO RELEASE INFORMATION

*Parent or Guardian Name: _____

Date of Birth: _____ **Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I do herby authorize to furnish the requested information to:

NAME: Early Learning Coalition of Alachua County
ADDRESS: 4424 NW 13th Street A-5
CITY: Gainesville **STATE:** Florida **ZIP CODE:** 32609

Any information concerning the age, residence, citizenship, employment, applications for employment, education and training activities, income, resources and any additional information involving eligibility of public assistance for myself and/or those individuals on whose behalf public assistance benefits are paid to me. It is understood that the information obtained will be used only for the purposes directly related to the eligibility of individuals on the public assistance case.

PARENT OR GUARIAN'S SIGNATURE: _____

DATE SIGNED: _____ (Valid for 48 months from date signed)

*Please have an Authorization of Release Information Form signed for each participating member of your household who is over the age of 18.

**SSN Optional