

CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION

The provision of your social security number is voluntary. Failure to provide your social security number may result in an information processing delay.

Individual Who is Subject of Record

Name	Social Security Number (SSN)	Date of Birth	
Street Address	City	State	Zip Code

Person or Organization to Whom Information May be Released

Name	Organization		
Street Address	City	State	Zip Code

Name and Address of Child Support Agency Being Authorized to Release Information

Name Marinette County CHILD SUPPORT AGENCY	Street Address		
City 1926 Hall Ave Marinette, WI 54143-1717	State	Zip Code	

Specific Records Authorized for Release (include dates of records, if applicable)

Case information which a child support agency may release to the individual.
 Note: Internal Revenue Service regulations prohibit release of any IRS data to any people other than to the involved parties. If the information in question was initially from the IRS, it cannot be provided.

Purpose or Need for Release of Information (be specific)

I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization remains in effect until the expiration time I have indicated and initialed below.

- Authorization expires as of _____ (Date)
- Authorization expires 12 month(s) from the date I sign this authorization.
- Authorization expires after the following action takes place:

I understand that if I am protected by a restraining order or I have reason to believe I may be harmed emotionally or physically, I have a right to request that information on my whereabouts be withheld from anyone including other parties to my court case. I hereby release the Department of Workforce Development and its designee named above from liability for the release of any information authorized under this agreement.

As evidenced by my signature below, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.

Signature of Individual Who is Subject of Record	Signature of Witness, if any	Date Signed
Signature of Other Person Legally Authorized to Consent to Disclosure (if applicable)	Title or Relationship to Individual Who is Subject of Record	Date Signed

Re: 95 CFR 303.21

DCF is an equal opportunity employer and service provider. If you have a disability and need to access this information in an alternate format, or need it translated to another language, please contact (608) 266-9909 or (800) 947-3529 WTRS (Toll Free).