State of Illinois
Department of Human Services

CONSENT TO RELEASE INFORMATION

Date: ____________________

14b5f460-ef13-40b3-8ea3-67040e957201

NAME: ____________________
ADDRESS: ____________________
ADDRESS: ____________________
CITY, ST. ZIP ____________________

Case Number: ____________________
Office Name: ____________________
Office Address: ____________________

Phone: ____________________
TTY: ____________________
Fax: ____________________

Tenemos este aviso en español. Para solicitar avisos en español, por Internet vaya al sitio ABE-MMC o llame al 1-800-843-6154 (TTY 1-866-324-5553 TTY/ Nextalk, 711 TTY Relay).

You can manage your account online at abe.illinois.gov

In order that the Department of Human Services can determine my (our) eligibility for benefits, I (we) hereby authorize

I (We) ☐ (receive) ☐ (have applied for) Cash, Medical and/or SNAP Assistance.

In order that the Department of Human Services can determine my (our) eligibility for benefits, I (we) hereby authorize:

____

to make available to the Department of Human Services or any properly identified representative of said Department information regarding:

____
Present Address

____
Former Address

____
Printed Name

____
Name of Spouse (if applicable)

____
Signature

____
Signature of Spouse

____
Name of Witness to Signature

____
Signature of Witness

____
Date:
This authorization is not valid more than 90 days beyond the date of signature.