



*A Community Action Agency*

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**Release of Information for OLHSA’s Older Adult Service Programs**

I \_\_\_\_\_ declare to the best of my knowledge, I am the only member of my household designated above who has applied for assistance in this program. I certify that my household meets the income guidelines of this program. I authorize OLHSA to verify information I have provided regarding income by waiving my rights to privacy concerning such records. Further, I certify that all information on the application is true and correct realizing misrepresentation is illegal and violations will be pursued. I hereby release any information on the application to agencies to which I may be referred.

I also declare that I am a person 60 years or older, handicapped, or low income. As a recipient of OLHSA older adult services programs funded by the Area Agency on Aging 1-B (AAA1-B) funds. I give my consent to release information about myself, which may be necessary to secure services, follow-up assistance, and that emergency information can be shared and /or emergency contacts notified in the event of an emergency. I understand that this information will only be released to an appropriate management person, applicable funding source representative, or emergency contact while I am a client of an OLHSA program. I hereby fully indemnify and hold harmless the OLHSA Board, Staff, Administration, AAA1-B, and assigns from any and all expenses and liability of any kind which may arise out of or in connection with the performance of OLHSA’S Older Adult Services Program.

\_\_\_\_\_  
Participant’s Printed Name

\_\_\_\_\_  
Participant/Proxy Signature

\_\_\_\_\_  
Date

Other Referrals Made:

I give my verbal release of info for these follow up referrals. Worker list referral, initial and date.

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