

## Release of Confidential Information

In order to provide services to you, it will be necessary for the Work Incentive Network to release and receive your confidential information. **At your request we can arrange for a different release of information agreement to satisfy a specific need or privacy concern.**

I, \_\_\_\_\_ do hereby authorize the staff members of the Work Incentive Network to share my confidential information, as necessary, to provide services as requested and to act on my behalf. I understand in order to receive WIN services without limitations or conditions that my confidential information must be shared. I further understand that medical or health records are not needed for WIN services and will NOT be requested.

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**Please read and initial at both lines if you agree to the terms:**

\_\_\_\_\_ I authorize staff members of the Work Incentive Network to release information from my confidential records to ALL APPLICABLE PARTIES/AGENCIES related only to work incentives planning. Medical and health records are not needed for WIN services and will NOT be requested.

\_\_\_\_\_ I authorize staff members of the Work Incentive Network to request and receive information from my confidential records from ALL APPLICABLE PARTIES/AGENCIES related only to work incentive planning. Medical and health records are not needed for WIN services and will NOT be requested.

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The Work Incentive Network is a network of 6 Centers for Independent Living in Oregon (Eastern Oregon Center for Independent Living, HASL Independent Abilities, SPOKES Unlimited, Abilitree, Independent Living Resources, Lane Independent Living Alliance) that work collaboratively to deliver work incentive services across the state. By signing this release, I consent to providing my social security number to the Work Incentive Network and to having it be printed in full on documents that are related to the services I am requesting from the Work Incentive Network. I further consent to documents that contain my social security number in full being mailed, faxed, or otherwise disseminated as needed in order to obtain the assistance I have requested from the Work Incentive Network. I provide this consent in order to allow the Work Incentive Network to comply with the Oregon Consumer Theft Protection Act. In all events, the Work Incentive Network will ensure use of my social security number is only for the purposes specified in this release and that all personal information, including my social security number, will otherwise be kept confidential. At any time you can withdraw your permission for this release of information. This release is valid for 180 days from the signature date.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date