Authorization to Release Information

(To be completed by applicant)

I hereby authorize the following licensed professional (doctor, therapist and social worker) who can verify my disability or health related condition, to release this information to Long Beach Transit Dial-A-Lift. This information will be used only to verify my eligibility for Long Beach Transit Dial-A-Lift. I understand that I have the right to receive a copy of this authorization, and that I may revoke it at any time.

Name of Professional who may release my medical information:

____

Address:

____

Street

City Zip Code

Medical Record or ID #, if known: _____________________

Phone number: (______) _________________________

Fax number: (______) _________________________

Signature:

Applicant's Name (Print):

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Applicant's Signature:_____________________________

Date:________________