

**Ohio Department of Aging
Authorization for Release of Information**

Name _____

Address _____

City _____ State _____ Zip _____

Telephone number _____ (____) _____ - _____

I _____, hereby grant _____ (or any
(print constituent's name) (print legislator's name)

member of their staff) authority to obtain information on my behalf from the Ohio Department of Aging or Area Agencies on Aging to complete my inquiry.

I maintain the right to rescind this authorization at any time.

Constituent's Social Security Number _____

Address _____

County _____

City _____ State _____ Zip _____

Telephone number(____) _____ - _____

Signed _____ Date _____
(Signature of Constituent)

**Please fax to the Legislative Liaison, Ohio Department of Aging
(614) 995-1049.**
