REQUEST FOR AND AUTHORIZATION TO RELEASE INFORMATION

Name: _____

Last 4 Digits of Social Security:_____

Date of Birth:_____

I hereby authorize **United Way of Northeastern Minnesota** and its program **United for Veterans** to obtain and release any and all information to and from the following:

(Check all that apply)

☐ **VA Clinic – Hibbing**
990 W 41st Street
Hibbing, MN 55746

☐ **County Veteran Service Office** *(location dependent on your residency)*
Duluth, Ely, Grand Rapids, Hibbing, Virginia

☐ **Minnesota Assistance Council for Veterans**
(MAC-V)
5209 Ramsey Street
Duluth, MN 55807

☐ **MN Military Family Assistance Center**
4015 Airpark Blvd
Duluth, MN 55811

☐ **Range Transitional Housing Virginia/Hibbing**
442 Pine Mill Court
Virginia, MN 55792

☐ **Housing & Redevelopment Authority – St. Louis or Itasca County** *(location dependent on your current residency)*

Other: _____
_____
_____
_____

The record release is required for: _____
_____
_
_____
_

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by United Way of Northeastern MN. Without my express revocation, the authorization will automatically expire one (1) year from my dated signature below.

Date *(mm/dd/yy)***:**_____

Signature of veteran or person authorized to sign for veteran:_____