State of Illinois
Department of Human Services

CONSENT TO RELEASE INFORMATION

Date: _____

14b5f460-ef13-40b3-8ea3-67040e957201

Case Number: _____

Office Name: _____

Office Address: _____

_____

Phone: _____

TTY: _____

Fax: _____

NAME: _____
ADDRESS: _____
ADDRESS: _____
CITY, ST. ZIP _____

Tenemos este aviso en español. Para solicitar avisos en español, por Internet vaya al sitio ABE-MMC o llame al 1-800-843-6154 (TTY 1-866-324-5553 TTY/ Nextalk, 711 TTY Relay).

You can manage your account online at abe.illinois.gov

In order that the Department of Human Services can determine my (our) eligibility for benefits, I (we) hereby authorize

I (We) ☐ (receive) ☐ (have applied for) Cash, Medical and/or SNAP Assistance.

In order that the Department of Human Services can determine my (our) eligibility for benefits, I (we) hereby authorize:

_____

to make available to the Department of Human Services or any properly identified representative of said Department information regarding:

_____
Present Address

_____
Former Address

_____ _____
Printed Name Name of Spouse (if applicable)

_____ _____
Signature Signature of Spouse

_____ _____
Name of Witness to Signature Signature of Witness

_____
Date:
This authorization is not valid more than 90 days beyond the date of signature.