MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

AUTHORIZATION FOR RELEASE OF INFORMATION

FROM	LIHEAP Worker Name	Telephone Number	Date
	LIHEAP Agency Name CAPNCM	LIHEAP Agency Address CAPNCM c/o LIHEAP 1506 Oklahoma Ave Trenton MO 64683	
TO	Name		
	Address		
RE	Applicant Name	Applicant DCN	

I authorize the release of information regarding my situation described below to representatives of the Missouri Family Support Division. (Circle the applicable situation and explain, if necessary)

Weatherization ☐

Lifeline ☐

Safelink ☐

Other (Explain) ☐

I (we) hereby release any person, representative of the Missouri Family Support Division, or representative of the LIHEAP contract agency from any liability for information furnished pursuant to this authorization.

Applicant Signature	Date
Signature of Other (If applicable)	Date