

Social Services

1000 Belle Terre Blvd
Palm Coast, FL 32164



www.flaglercounty.org

Phone: (386)586-2324

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Applicant's Statement, Authorization for Release of Information

CHAPTER 837.06

"Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor of the second degree, punishable by imprisonment according to Florida Statute 775.082."

I **hereby certify** that I have been a resident of Flagler County for at least six (6) months and declare my intention of remaining in Flagler County. By signing my name to this form, I am saying that the answers I give or have given are **true and complete** to the best of my knowledge. I know that if I give **wrong information or withhold information on purpose, I am breaking the State Law and am subject to penalties provided by Law, including the penalty for Perjury.**

I **hereby grant permission** and authorize any insurance company, employer, utility company, bank or financial institution of any kind or character to disclose to the Board of County Commissioners and/or the Flagler County Social Services Department/Human Services Division (FCHS) full information regarding any past, present, or pending earnings and assets. I hereby waive any privacy rights that I may have under State or Federal Law concerning my income, assets, liability or assistance received from such agency, and I further consent and request that any State or Federal agency having information concerning me, disclose same to the Board of County Commissioners of Flagler County, Florida or its agents.

I **hereby grant permission** to the Board of County Commissioners and FCHS to share information regarding my past, present or pending income and assets with other social service agencies that are providing financial assistance to me.

I **also authorize the release** of any medical and/or psychiatric or psychological information to the above named parties.

I **give my permission** to the Flagler County Social Services Department/Human Services Division to forward any information as necessary to hospitals, physicians or other medical professionals involved in providing my medical care.

I **understand that this form will be valid for the period of one year from the date it was signed.**

I _____, do swear or affirm that I am a resident of Flagler County, Florida
Applicant's Name – Printed

and the information given on this application is true and complete. I have read and understand the above statements and releases.

Applicant Signature: _____

Signature, Spouse or companion: _____

Witnessed: _____ Date: _____

Form 103 Revised: Feb 2012