

DEPARTMENT OF TRANSITIONAL ASSISTANCE
Permission to Access DTA Client Case Information

REQUEST FOR ACCESS TO CLIENT RECORD OF: _____
(Print Client's Full Name)

1. Client Information:

Date of Birth ___/___/___ Address: _____

Last 4 digits of SS#: ___ ___ ___ ___ or DTA "Agency ID" number: _____

2. I hereby authorize _____
(organization's name and city/town)

to have access to my DTA case record and case information, including any electronic records. I authorize this organization to discuss my application or benefits with a DTA case manager, supervisor, director or other DTA employee. This form is valid for 12 months unless I have stated otherwise on this form or in other communication.

3. I hereby certify that I am the client named above.

Client Signature Date

→ **Mail to** DTA Document Processing Center, P.O. Box 4406, Taunton, MA 02780,
or by **fax to** (617) 887-8765.

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- This form gives permission to helping organization or other third party to speak with DTA, and for DTA to share information about the client's case. If client needs an authorized representative to sign DTA paperwork and/or get an EBT card to food shop, use DTA's Image 10 form.
 - Acceptable written authorization includes this form, a hand written statement or DTA's Voluntary Consent to Release Information form (VARI-OI). Oral consent by the client (data subject) also acceptable. 106 CMR 104.040.