AUTHORIZATION FOR CONSENT TO RELEASE INFORMATION

State Form 56650 (1-19)

INDIANA DEPARTMENT OF VETERANS AFFAIRS
Indiana Veteran's Center
777 North Meridian Street, Suite 300
Indianapolis, Indiana 46204-2738
Telephone: (317) 232-3910
Fax: (317) 232-7721
Website: www.in.gov/dva

I_____, hereby authorize the Indiana Department of Veterans' Affairs access to obtain information pertaining to my financial institution, billing/payment information and employment history. I fully release the Indiana Department of Veterans' Affairs, and any and all employees, directors, and agent's permission to request verification of any information provided to them by me from the vendors in which I am requesting assistance with. I agree to willingly provide any information required to assist in this process.

It is to my understanding that the information being obtained will only be used in determining my eligibility for the Military Family Relief Fund and any other services I may apply for through the Indiana Department of Veterans' Affairs. I understand that the individuals reviewing my case determines the outcome and can decide to allocate funds approved directly to the vendors.

I hereby state that all information I have provided to the Indiana Department of Veterans' Affairs, in any form, is true to the best of my knowledge. I understand that any known misrepresentation made to the Indiana Department of Veterans' Affairs will result in denial of services and may exclude me from further consideration for services requested. Any information being obtained will not be used in violation of any federal or state law or regulation.

Applicant	Spouse
_____	_____
Printed Name and Title	Printed Name and Title
_____	_____
Authorized Signature Date *(month, day, year)*	Authorized Signature Date *(month, day, year)*

For Official Use Only

Date Received *(month, day, year)*:_____ Received By: _____