



Authorization to Release Information

(To be completed by applicant)

I hereby authorize the following licensed professional (doctor, therapist and social worker) who can verify my disability or health related condition, to release this information to Long Beach Transit Dial-A-Lift. This information will be used only to verify my eligibility for Long Beach Transit Dial-A-Lift. I understand that I have the right to receive a copy of this authorization, and that I may revoke it at any time.

Name of Professional who may release my medical information:		

Address: _____		
Street	City	Zip Code
Medical Record or ID #, if known: _____		
Phone number: (_____) _____		
Fax number: (_____) _____		

Signature:

Applicant's Name (Print): _____

Applicant's Signature: _____ Date: _____