



**Housing Improvement Program  
Consent for Release of Information  
Health and Disabilities**

Name of Health Facility: \_\_\_\_\_

Name of Doctor (if applicable): \_\_\_\_\_

I / We do hereby give my consent to release to Kawerak, Inc. Housing Improvement Program (HIP) information on my health and disabilities, for the sole purpose of obtaining housing assistance.

In the essence of cooperation Kawerak Inc. HIP may share this confidential information only with another housing agency for the sole purpose of assisting me to obtain housing assistance.

Please provide any information they may require.

Thank you,

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date

**\* This information is CONFIDENTIAL in nature and is only for the Housing Department of Kawerak, INC. If you have received this document in error please contact the Housing Department of Kawerak and/or Destroy promptly.**