



*C.U.B.S. (Calloway United Benevolent Services) network is composed of approximately 150 agencies, organizations, churches, institutions and other entities dedicated to the well-being and achievement of every potential member in our community. At any point that an individual family with multiple needs makes contact with the network, we request your permission to activate the network and other community resources to address those needs.*

**C.U.B.S. Consent Form**

*(Please Print Clearly)*

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Additional Household Members:**

Name	Relationship	Birthdate	Social Security Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I hereby authorize members of C.U.B.S. to exchange, release or obtain confidential information regarding the above-named individual, the minor children in said individual's family unit or to represent said person(s) to other agencies or persons. If any agencies or persons are to be excluded from contact, please list below in the space provided.

\_\_\_\_\_  
 \_\_\_\_\_

I understand that the above consent form releases those in C.U.B.S. from any and all liability which may result from said confidential information. I also understand that I may revoke this consent in writing at any time and that should I do so, no further information will be released. Unless earlier revoked, this consent shall expire one (1) year from the date below.

\_\_\_\_\_  
 Client(s) Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Agency Representative Signature

\_\_\_\_\_  
 Date