



Authorization to Confirm Enrollment

With your County Developmental Disability Program

To confirm that you (or your family member) is a person with an intellectual and developmental disability, please authorize your county Developmental Disability Program to release information about whether or not you are enrolled in their program.

This is to authorize our county DD Program office

_____ to release information to (Name of SNF volunteer) that that I (or my family member) is enrolled in our local DD program.

(sign)_____

Your Signature for children up through age 17

(sign)_____

My signature for individuals 18 and over

Date Signed_____