DEPARTMENT OF TRANSITIONAL ASSISTANCE
Permission to Access DTA Client Case Information

REQUEST FOR ACCESS TO CLIENT RECORD OF: _____
(Print Client's Full Name)

1. Client Information:

   Date of Birth _____ Address: _____

   Last 4 digits of SS#: __ __ __ __ or DTA "Agency ID" number: _____

2. I hereby authorize _____
   (organization's name and city/town)
   to have access to my DTA case record and case information, including any electronic records. I authorize this organization to discuss my application or benefits with a DTA case manager, supervisor, director or other DTA employee. This form is valid for 12 months unless I have stated otherwise on this form or in other communication.

3. I hereby certify that I am the client named above.

_____ _____
Client Signature Date

→ Send through **DTA Connect** (DTA's mobile app),
F**ax to** (617) 887-8765,
Mail to DTA Document Processing Center, P.O. Box 4406, Taunton, MA 02780 OR
Bring in person to a local DTA office