# AUTHORIZED REPRESENTATIVE

_____ , 20 _____

**State of California**
**Department of Social Services**
**P.O. Box 944243, M.S. 19-37**
**Sacramento, California 94244-2430**

I, _____ of
(Name)

_____ _____
(Address) (City, State and Zip)

have requested _____
(Name)

_____
(Organization)

_____ _____
(Address) (City and Zip)

to act on my behalf in my appeal regarding my application for and/or receipt of _____

_____
(Assistance Program)

I hereby authorize your department to release any or all information relating to this request to this person/organization.

Signed _____