Security for People with Special Needs since 1990

office | 804.740.6930 toll free | 888.241.6039 fax | 804.740.6065
address | PO Box 29408, Richmond, VA 23242-0408

Consent for Release of Information

Please complete this form to give CCT staff permission to speak with the individual(s) or agency listed below regarding the Beneficiary's trust. The form must be completed and signed by an Advocate for the trust.

Beneficiary Name: ______________________ Account Number: ______________

I give CCT permission to speak with the following:

Name(s): ______________________________________

and/or

Agency/Business: ______________________________________

Phone Number: ____________________ Email Address: ____________________

Address: ______________________________________

____

Completion of this form does not give the above individual/agency authorization to submit Payment Request Forms for disbursements from the trust.

Completed By:

____________________	____________________	__________
(Advocate Name)	(Advocate Signature)	(Date)