Consent for Release of Information - SYEP
Department of Social Services
Division of Family Independence | Comprehensive Employment Division
B-632 SYEP (4/2024)

Name of Parent/Guardian/Applicant (if Head of Household)	Date
Summer Youth Participant Name	Date of Birth
Time Period of Release May 1, 2024 to September 30, 2024	

Please check all boxes below in which you are providing consent:

☐ I, the undersigned, hereby give my consent to the Erie County Department of Social Services to release information relating to my eligibility for Temporary Assistance, Supplemental Nutrition Assistance Program (SNAP) and other benefits under the Social Services Law, to the Summer Youth Employment Program Community Agency for evaluation of eligibility to participate in the program supported by the Erie County Department of Social Services.

☐ I, the undersigned, grant permission to Erie County Department of Social Services to use the above-named Summer Youth Participant's image (photographs and/or video) for use in media publications. I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

☐ As interviews may be conducted, I give consent for such interview content with the above-named youth to be used for the purpose of advertising, reporting and recruiting for the program.

By signing below, I attest that I can read and write English. If not, I have had this read to me or been provided an interpreter and understand this release as it has been explained to me.

I, the undersigned, grant permission for the above-named youth to participate in the Summer Youth Employment Program.

I understand that this permission may be revoked and understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

A COPY OF THIS AUTHORIZATION MAY BE USED IN LIEU OF AN ORIGINAL.

Signature of Parent/Guardian/Applicant (if Head of Household)	Printed Name	Date
Department Representative (for Youth in Foster Care)	Printed Name	Date