

**United Cerebral Palsy of Tampa Bay, Inc. dba Achieve Tampa Bay
2215 East Henry Avenue Tampa, FL 33610
Phone- 813-239-1179 Fax-813-237-3091**

**AUTHORIZATION FOR RELEASE OF INFORMATION
DEVELOPMENT DEPARTMENT**

Participant's Name

Phone Number

Address

City/State

Zipcode

I hereby knowingly and voluntarily authorize United Cerebral Palsy of Tampa Bay, Inc. dba Achieve Tampa Bay to release my name, address and phone number to its Development Department. The Development Department may:

_____ Send me newsletters, annual reports or other printed information about the agency.

_____ Contact me as part of a fund raising effort. I have the right to request not to receive subsequent fund raising materials.

The Development Department will not sell or give my name, address or phone number to other individuals or entities.

This authorization shall remain valid as long as the participant remains in the program or until such time as I present a written revocation of this authorization to the agency.

Signature of Participant or Legal Representative

Witness

Date: _____

Date: _____

Relationship to Participant

Original document filed in Participant's record
cc: Development Department