# **North Carolina Department of Health and Human Services**

# **Division of Aging and Adult Services**

**Consent and Authorization for Access to Financial Records**

**(NCGS53B)**

I, reside at the following address:

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| --- |
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I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ disclose the applicable records as (Financial Institution)

described herein concerning me to the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ county (NC) Department of

(Name of County DSS)

Social Services (DSS) for the purpose of determining the need for Adult Protective Services. The

financial institution may provide all information regarding my accounts as well as copies of any

and all financial records and supporting documents as indicated below:

☐ Current balance(s)

☐ Statements for the time period of:

☐ Copies of checks and transactions for the time period of:

☐ Existence and location of safe deposit box

☐ Other:

**Statement of Consumer Rights Under the North Carolina Financial Privacy Act**

None of my financial records may be disclosed by the financial institution except in accordance with the terms of this consent or a duly issued judicial order or subpoena; and I understand that if the financial institution discloses any of the financial records or the government authority obtains any information about my financial records in violation of the North Carolina Financial Privacy Act (Chapter 53B of the North Carolina General Statues), I may sue for damages as provided in the Act. I further understand that:

* I have the right not to give this consent,
* This consent may not be revoked without 5 days’ notice or if action has been taken in reliance on it.
* This consent will be valid for 6 months,
* Giving this consent cannot be made a condition of doing business with any financial institution,
* I have the right to access the financial institutions’ record of disclosures pertaining to my accounts.

I certify that I have read this consent or that it has been read to me, that I understand its terms and the nature of the information requested, and that I voluntarily signed it on the date appearing beneath my signature.

Please deliver information to:

County DSS

Attn:

Mailing Address: Signature of Client

Date of Signature

Social Worker Name:

Social Worker Telephone Number: