AUTHORIZATION FOR RELEASE OF INFORMATION

MEMBER NAME: ____________________________ ACCOUNT NUMBER: ______________

I, ____ give authorization to Compassionate Care Credit Union to provide information to ____ at
(Name of Individual/Business)

____ or
(Insert mailing address)

_____________________________________.
(Insert fax number)

By signing below, I understand that if this information is faxed it may be received at a fax machine that is not private. I agree to hold Compassionate Care Credit Union harmless if the information is viewed by an unauthorized person.

____ _____________________
Member Signature Date

For Office Use Only:

Sent by: _________________________ Date: _____________________ Time: ______________

Physical Address: 430 E Division St, Fond du Lac, WI 54935
Mailing Address: P O Box 1474, Fond du Lac, WI 54936-1474
P: (920) 926-4980 F: (920) 926-8996 E: info@wecarecu.org