**Support Consent Affidavit Form**

**Affidavit of Support Consent**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, residing at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby declare my consent for the following purpose related to support as outlined below.**

**Recipient's Information  
Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Relationship to Affiant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Purpose of Consent**

| **Support Type** | **Amount or Value** | **Frequency** | **Conditions** |
| --- | --- | --- | --- |
| **Financial Support** |  |  |  |
| **Educational Support** |  |  |  |
| **Medical Support** |  |  |  |
| **Other:** |  |  |  |

**Validity of Consent  
This consent shall remain valid until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or until revoked in writing by the undersigned.**

**Affirmation  
I declare that the above information is true and that this consent is provided voluntarily.**

**Signature and Date  
Affiant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**