QC 1ARI
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Louisiana Department of Health
Economic Stability
Supplemental Nutrition Assistance Program
SNAP – Quality Control

Date: ______________________
Review Number: ______________________
Case ID: ______________________
QC ES Specialist: ______________________

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, ______________________ , residing at, ______________________
hereby authorize the Quality Control (QC) Unit to verify my income, bank accounts, shelter expenses, medical expenses, insurance, disability or retirement benefits (Social Security, Supplemental Security Income, Veterans Administration, etc.), medical history, information on my Social Security Number record, and any other facts relevant to my eligibility. I also authorize any person, partnership, corporation, association, or governmental agency processing information on such matters to release such information to the QC ES Specialist.

(Signature)	(Date)	(Spouse's Signature)	(Date)
(Witness)	(Date)	(Witness)	(Date)
QC ES Specialist		(Date)	