Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Citizens with Developmental Disabilities

RECIPIENT'S CONSENT FOR AUTHORIZED REPRESENTATION

Recipient's Name	**SSN #**	**ID#**

I understand that all information gathered, on my behalf and/or for those persons for whom I am responsible, is personal and confidential. My decision to appoint an Authorized Representative is optional, made freely, and does not relieve me of my responsibility to actively participate in the waiver service evaluation process. I understand that the function of the Authorized Representative is to accompany, assist, and represent me in the waiver evaluation process, and to aid in obtaining all necessary documentation for the agency's evaluation for Home and Community-Based waiver services. I also understand that my authorized representative has the power to make decisions for me concerning all aspects of various waiver programs administered by the Department of Health and Hospitals (DHH). I understand this may require the Department to disclose information to the representative named below that may otherwise be confidential. I hereby waive any rights I may have to prevent disclosure by the Department to the authorized representative named below.

I understand that this authorization is limited solely to the individual named below and is valid until revoked by me. I further understand that I may cancel my appointment of the individual(s) named below as my Authorized Representative at any time upon written notice to the Department.

I understand that while some of the information gathered may have no impact on my waiver services evaluation, it may affect my liability to a third party should this information be disclosed to the third party by my Authorized Representative. I hereby hold the Department of Health and Hospitals (DHH) harmless for any claim resulting from disclosure of information to a third party by my Authorized Representative.

I understand that if this authorization is not signed in the presence of agency staff or a program representative, a confirmation of authenticity may be conducted by agency staff.

Authorized Representative Name:_____

Address: _____

Telephone Number (Home):_____ (Work)_____

Authorized Representative Signature:_____

Date:_____

Recipient's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

Support Coordinator's Signature: _____ Date: _____