LOUISIANA DEPARTMENT OF HEALTH
Office for 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, abridge, or abrogate my responsibility or right 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 Louisiana Department of Health (LDH). I understand this may require LDH to disclose information to the representative named below that may otherwise be confidential. I hereby authorize release of protected health information (PHI) and other confidential documents to the Authorized Representative named below.

I understand that this authorization is limited solely to the individual(s) named below, and is valid until revoked by me in writing to the Office for Citizens with Developmental Disabilities. I further understand that I may cancel my appointment of the individual(s) named below as my Authorized Representative(s) at any time upon written notice to the Office for Citizens with Developmental Disabilities; however my revocation will not apply to information that has already been released to my Authorized Representative(s).

I understand that information disclosed to my Authorized Representative(s) may be redisclosed and no longer protected by LDH privacy policies. I also 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 Louisiana Department of Health 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.

_____ _____ _____

Recipient's Name SSN # ID#

Authorized Representative Name: _____

Address: _____

_____

Telephone Number (Home): _____ Work: _____

Authorized Representative Signature: _____

Date: _____

Recipient's Signature: _____ Date: __ _____

Witness Signature: _____ Date: _____

Support Coordinator's
Signature: _____ Date: _____

NOTE: The Recipient must personally sign or make their mark on this document to have an authorized representative if they are a competent major. The Local Governing Entity and Support Coordination must retain proof of legal guardianship/status if the recipient is not a competent major (i.e. court order).