BHSF Waiver Rev. 01/01 Prior Issues Usable

## Medicaid Program Waiver of Confidentiality

All information gathered o permission to release the in		-	onal and confidential. The following is written low.
I understand that the inform	mation ir	the record of:	
Name		_ SSN	Case ID #
Address			·····
Is personal and confidentia	al. Howe	ever, I give my p	permission for:
Name			
to release to:			
☐ Louisiana's  Medicaid Program	OR	□ Name:	
		Address: _	
		City/State/2	Zip:
☐ the information requested on attachmen for the specific purpose		Other:	
<ul><li>determining Medicaid eligibility</li></ul>	OR	Other:	
I understand that my perm any time except when the			ormation may be canceled by me in writing at been released.
Signature of Applicant/Recipier	Date		
<u> </u>	sted abo	ve and has the	/guardian/custodian/authorized representative egal authorization to sign on behalf of the
Signature of Authorized Repres	Date		
Signature of Witness	Date		
Signature of Witness		 Date	