Authorization to Release Information

Personal Physician, Hospital or Clinic

Claimant Name: _____ SSN: _____

Provider Name: _____

I hereby authorize the above named source to release any information to the local Department of Social Services and State Review Team all information concerning me including records, test results and my medical history. A photostatic copy of this authorization shall be valid as the original.

This information is being requested for the purposes of establishing eligibility for Medical Assistance benefits.

This authorization is effective for one year from the date below. It may be revoked at any time except to the extent that it has already been relied upon.

_____ _____

Signature of Claimant Date