CONSENT FOR RELEASE OF INFORMATION

REGARDING AN APPLICATION/REDETERMINATION FOR MEDICAID
LONG-TERM CARE BENEFITS

This form authorizes information to be released from the Local Department of Social Services to the Long Term Care facility

I,_____, authorize

the _____Department of Social Services to release all information contained in, and concerning the status of, my application/redetermination for Medicaid benefits, as a long-term care resident at the following nursing care facility.

Name of facility Address

This information may be released to the following person (s):

_____ _____
Name (please print) Position

_____
Telephone Number

_____ _____
Name (please print) Position

_____
Telephone Number

_____ _____
Name of applicant/recipient (please print) CID #

_____
Signature of applicant/recipient or authorized representative

_____
Applicant/recipient Social Security Number

Date _____

This form is valid for 12 months from date of signature.