Authorization to Release Health/Medical Information

I hereby authorize Southwest Mississippi Planning and Development District/Area Agency on Aging - Elderly and Disabled Medicaid Waiver Case Managers to disclose my health and medical information as described below:

Client Name:	Social Security Number:	Date of Birth:
Name and address of person(s) and/or organization(s) to which the information may be disclosed:		
The following information may be disclosed:		
The above information may be disclosed for the purpose of:		

Legal Authority for Request (please initial):
I am the client noted above.
I am the client's legally authorized representative who has authority to act on behalf of the client.

Understanding and Agreements of Requestor:

I understand that this authorization is voluntary and I may refuse to sign. I may revoke this authorization at any time by notifying the agency in writing, but if I do, it will not have any effect on my actions taken prior to receiving the revocation.

Otherwise, this authorization will be in effect for as long as I am a participant in the HCBS program..

Signature:	Date Signed: