STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
**DIVISION OF WELFARE AND SUPPORTIVE SERVICES**

STEVE SISOLAK
*Governor*

RICHARD WHITLEY, MS
*Director*

STEVE H. FISHER
*Administrator*

☐ TANF ☐ MEDICAID ☐ SNAP

Date: _____
Case Name: _____
Case ID: _____

# AUTHORIZATION FOR RELEASE OF INFORMATION

**RE:** _____ **SSN:** _____

You are authorized by the undersigned to release to or obtain from the Nevada State Division of Welfare and Supportive Services the information including, but not limited to, that indicated below. This authorization constitutes a full and complete release from any liability resulting from disclosure of such information. I hereby consent to the disclosure of my identity and waive my right as an older person to have my identity kept confidential. This authorization also permits release of medical information under the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) and Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (P.L. 93-282). A photocopy of this form shall be as valid as the original.

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|---|---|
| ☐ | Authorization for medical data including, but not limited to, admission history and physical progress notes, discharge summary, operative report, laboratory test results and consultant reports. |
| ☐ | Authorization for undefined |

This authorization for release shall be valid for one (1) year.

| Signature | Print Name | Title/Relationship | Date | Telephone Number |
|---|---|---|---|---|

*Please return this form to the address above.*