RESET FIELDS

pennsylvania
DEPARTMENT OF PUBLIC WELFARE
www.dpw.state.pa.us

AUTHORIZATION FOR RELEASE OF INFORMATION

APPLICANT'S NAME	SOCIAL SECURITY NUMBER
ADDRESS	ZIP CODE

I give my permission to the Department of Public Welfare to act as my representative in connection with the verification requirements for age, citizenship, identity, income and resources pertaining to the eligibility requirements for health care coverage under Medical Assistance program. This authority grants permission for the release and disclosure of information to the Department of Public Welfare. The information obtained will be used only for the purposes directly related to eligibility for health care coverage.

Signature of Applicant or Authorized Representative (Applying on behalf of applicant) — Date

Signature of Witness (if applicant signed with a mark) — Date

Name of Authorized Representative	Telephone Number
Address of Authorized Representative	Relationship to Applicant