Idaho Dept of Health & Welfare

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Authorized Representative

Please complete and return this form to a Department of Health and Welfare office

Client Name _____ Date of Birth _____ Telephone _____
(First, MI, Last)

Mailing Address _____ State _____ Zip Code _____

Requestor Information
(To be completed if authorization is being made by someone other than the subject of the information. Please provide documentation of your authority.)

Requestor Name (if different than client) _____ Telephone _____

Mailing Address _____ State _____ Zip Code _____

Authorization Details

I authorize the following individual, organization or business to be my authorized representative:

Name _____

Address _____ State _____ Zip Code _____ Telephone _____

As my authorized representative, they can report information, receive information and request changes to my case.

I understand that I may revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance upon this authorization

Client's Signature _____ **Date** _____

I understand that as an Authorized Representative, I am accountable for the information I provide on behalf of the client. I am responsible to have the information needed to assist Health and Welfare in determining eligibility.

Authorized Representative Signature _____ **Date** _____

Please fax completed form to 1(208) 799-3328