STATE OF KANSAS
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
ECONOMIC & EMPLOYMENT SUPPORT

07-2009
ES-3178

Authorization Form for the Release of Information

I hereby authorize the Nursing Facility listed below to inquire and receive information regarding my application and eligibility for Medicaid with the Kansas Department of Social and Rehabilitation Services (SRS). SRS may share with nursing facility listed below any information regarding my Medicaid eligibility status, pending questions regarding my eligibility, and patient obligation amounts.

Nursing Facility: _____

Address: _____

City, State Zip: _____

Telephone Number: _____

I authorize the release of this information to the facility named above for the following period of time:

From: ____ / ____ / _____ To: ____ / ____ / _____

Please retain this Authorization Form for Release of Information in your files for future inquiries from the person named above.

Member/Applicant Information

_____ _____
Resident's Name (please print) Social Security Number

_____
Address

_____
Name of Guardian/Conservator or Durable Power of Attorney (please print)

_____ _____
Signature of Resident, Guardian/Conservator or Durable Power of Attorney Date