Well-Ahead Louisiana Primary Care Office

State Loan Repayment Program

# Consent for Release of Information and Waiver of Confidentiality

I, Applicant’s Name, understand that the following information contained in my records may or may not be confidential. However, I give my consent for Certified Educational Lender to release to the Louisiana Department of Health information regarding my educational loan(s).

The information is to be disclosed for the specific purpose of applying for repayment of the loan(s) under the Louisiana State Loan Repayment Program for health care professionals. This consent is deemed to be continuous unless revoked by me in writing.

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Applicant Signature Date

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Witness Date

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Witness Date