Louisiana Physician Loan Repayment Program

Consent for Release of Information and

Waiver of Confidentiality

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that the following information contained in my records may or may not be confidential. However, I give my consent for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 Physician Loan Repayment Program. This consent is deemed to be continuous unless revoked by me in writing.

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**Applicant’s Signature**  **Date**

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**Witness** **Date**

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**Witness** **Date**