

Division of Senior and Disabilities PCA/CHOICE Programs

Authorization for Release of Information

(for enrollment and eligibility uses)

Legal Name (Last, First): _____

Medicaid: _____

CCAN#: _____

POC/Service Plan Start Date: _____

POC/Service Plan End Date: _____

Name: _____

Record # or Other ID: _____

Date of Birth: _____

Other Names Under Which Records Might be Filed: _____

Person/Organization Releasing Information: _____

Person/Organization Receiving Information: _____

Description of Information to be Released: *(If substance abuse information is to be released from a federally assisted substance abuse treatment center, then this information must be included in the description.)*

The purpose of the release of this information is:

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that my records *may* contain sensitive information. I understand that I may revoke this authorization at any time by signing the revocation section attached to this release, or by notifying the individual(s) or organization releasing this information in writing; but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information *may* condition payment, enrollment in a health plan and eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This consent to release information is valid for no more than one year from today's date.

Signature of Client: _____ Date: _____

Signature of Legal Representative*: _____ Date: _____

Witness #1 Signature: _____ Date: _____

Witness #1 Printed Name: _____

Witness #1 Relationship to Client: _____

Witness #2 Signature: _____ Date: _____

Witness #2 Printed Name: _____

Witness #2 Relationship to Client: _____

**Documentation of status as legal representative is attached, or has been submitted to DSDS at an earlier date.
(Two witnesses are required if client signs with an X. The Care Coordinator may not serve as a witness.)*

Note: This authorization was revoked on: _____ (See attached revocation.)

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of this information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information, if held by another party, is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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REVOCATION SECTION*

I do hereby request that this authorization to release the information of:

(printed name of client) described on the preceding page of this form, be rescinded, effective *(date)*. I understand that any action taken on this authorization prior to the rescinded date is legal and binding. I understand that this authorization to release information is required to ensure payment for health care services, enrollment in a health plan, or eligibility for benefits and that payment, enrollment and eligibility may now be seriously affected or denied altogether when this revocation goes into effect.

Signature of Client: _____ Date: _____

Signature of Legal Representative**: _____ Date: _____

Witness #1 Signature: _____ Date: _____

Witness #1 Printed Name: _____

Witness #1 Relationship to Client: _____

Witness #2 Signature: _____ Date: _____

Witness #2 Printed Name: _____

Witness #2 Relationship to Client: _____

***Documentation of status as legal representative is attached, or has been submitted to DSDS at an earlier date.
(Two witnesses are required if client signs with an X. The Care Coordinator may not serve as a witness.)*

** If this revocation section has been completed and signed, please note the date of the revocation on the previous page of this form in the space provided.*