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Authorization to Release Medical Information

SOURCE OF MEDICAL INFORMATION

Go To HIPAA Information on Page 2

Name:	Address:

I hereby authorize the above named entity to disclose the following information to the Department of Children and Families (DCF) or their designated agent(s), and to the Department of Health (DOH), Division of Disability Determinations (DDD) to determine my eligibility for health care program benefits:

☐ Medical records or other information regarding my treatment, hospitalization, and/or care;

☐ Information about how my condition affects my ability to complete tasks and activities of daily living;

☐ Information about how my condition affects my ability to work.

By my signature below, I affirm that I have read and understand the information on page two of this document, and understand my rights under the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2). I authorize you to release to the Department of Children and Families, or their designated agents, any health information you may have in your possession relative to my heath history.

This Authorization for the Release of Medical Information is valid for six months from the date signed.

_____ _____
Applicant's name (print) Applicant's Social Security Number

_____ _____
Signature of Applicant or Legal Representative Date Signed

If applicant or representative signs with a mark ("X"), a witness signature is required below:

_____ _____
Signature of Witness Date Signed

_____
Street Address City State Zip Code

This form must be signed by the applicant or someone with legal authority to sign on the applicant's behalf. If someone other than the applicant signs, please specify the legal authority to sign and complete the information below:

☐ **Power of Attorney** ☐ **Guardianship Papers** ☐ **Parental relationship (if applicant is a child)**

☐ **Other:**_____

_____
Address of person signing for applicant City State Zip Code

(_____)_____
(Area Code) Telephone Number

Go To HIPAA Information on Page 2

Name of individual authorized to receive requested health information on behalf of the applicant:

_____ (_____)_____ _____ _____
Name Phone Number Title Agency

Authorization to release the information described above to the entities listed is based on the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d-2, the Veterans Omnibus Health Care Act of 1974, PL 94-581, including the Drug Abuse Office and Treatment Act of 1972, PL 92-255, and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974, PL 93-282, and implementing federal regulations.

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This form will be used to request information related to your health, or health history from your medical provider. Federal law limits how this information may be used. The information the Department of Children and Families is requesting will be used in determining your eligibility for health coverage, determining your state of disability, or to carry out treatment, payment, or health care operations.

By signing this authorization you are allowing persons, or health care providers, in possession of information related to your personal health to release such information to the Department of Children and Families, or their designated agent(s), and to the Department of Health, Division of Disability Determinations to determine your eligibility for health care program benefits.

Go Back To Page 1

This release is time limited and is valid for the time period listed on page one of this document. You have the right to revoke or cancel this Authorization to Release Medical Information at any time. To cancel this release you must inform the Department of Children and Families in writing. For more information on how you can cancel this release please call your Department of Children and Families caseworker.

The information the Department of Children and Families receives may be shared with other agencies as allowed by law, only to the extent necessary to determine your eligibility for health coverage, or determining your state of disability, or to carry out treatment, payment, or health care operations, or as required by law.

If you do not agree to have your personal health information (or your child's information) released to the Department of Children and Families it could affect the Department of Children and Families ability to determine your eligibility.

If you do not sign this authorization it will not affect your eligibility for any other program where personal health information is not needed.