AUTHORIZATION FOR THE RELEASE AND EXCHANGE OF INFORMATION

Client Name: ____ Date of Birth: ____________________
(Please print)

I give permission for the MFP Transition Coordinators (TC), MFP office staff, Long Term Medicaid staff, my Long Term Medicaid case management agency, and the medical facilities listed below to share and disclose my medical information to one another. My medical information includes, but is not limited to, admission and discharge dates, medications, diagnoses, assessment and treatment plans, OT/PT/SLP or other therapy information.

Skilled Nursing and Medical Facility List (attach a separate sheet if necessary):

1. ____
2. ____
3. ____

Statement of Understanding – I Understand:

- That all information concerning me will be respected as confidential by these entities and that it will be used solely to facilitate MFP eligibility determination.
- I do not have to agree to the release of this information, and if I choose not to, any benefits to which I am entitled will not be affected. However, if I decline to release information, it may affect my eligibility for the MFP program.
- My drug and alcohol treatment records are protected by federal confidentiality rules (42 CFR Part 2) and cannot be disclosed or re-disclosed without my express written consent or as allowed by the regulation. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any drug or alcohol abuse patient.
- DAIL will take every precaution to protect my other health information (not alcohol/drug); it will not be knowingly re-disclosed to third parties without my express written consent.
- I may revoke this authorization at any time except to the extent that it has been acted upon. To revoke this authorization, I must contact my Transition Coordinator.
- If I do not revoke this authorization, it will be in effect until two years after the date of the MFP Transition Coordinator's signature below or the end of my MFP enrollment, whichever comes first.

____
Client or Legal Guardian Name (Please Print)

____ ____________________
Client or Legal Guardian Signature Date of Signature

____ ____________________
MFP Representative Signature Date of Signature