

## AUTHORIZATION TO DISCLOSE MEDICAID INFORMATION

To: \_\_\_\_\_

I, the undersigned, hereby authorize and request the above-named entity to disclose to the agents or designees of \_\_\_\_\_(VENDOR), any and all records containing Medicaid information, including those that may contain protected health information (PHI) regarding \_\_\_\_\_ (Name), whether created before or after the date of signature. This authorization should also be construed to permit agents or designees of \_\_\_\_\_ (VENDOR) to copy, inspect and review any and all such records. Records requested may include, but are not limited to:

all Medicaid records, including explanations of Medicaid benefit records and claims records; any statements, communications, pro reviews, denials, appeals, correspondence, reports, questionnaires or records submitted in connection with claims; all reports from physicians, hospitals, dental providers, prescriptions; correspondence, test results and any other medical records; records of claims paid to or on the behalf of \_\_\_\_\_ (Name); records of litigation and any other records of any kind. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of \_\_\_\_\_ (Style of Case) or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation. By signing this authorization, I expressly do not authorize any ex parte interview or oral communication about me or my medical history by \_\_\_\_\_(VENDOR) without the presence of my attorney.

### NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to \_\_\_\_\_(VENDOR), except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that they shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by \_\_\_\_\_(VENDOR).**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to \_\_\_\_\_(VENDOR).

\_\_\_\_\_  
Name of Individual

\_\_\_\_\_  
Signature of Individual or Individual

\_\_\_\_\_  
Former/Alias/Maiden Name of Individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Individual's Date of Birth

\_\_\_\_\_  
Name of Individual Representative

\_\_\_\_\_  
Individual's Social Security Number

\_\_\_\_\_  
Description of Authority

\_\_\_\_\_  
Individual's Address