Reset Form

DETERMINATION OF DISABILITY
Authorization for Release of Medical Information

State Form 44554 (R7 / 9-23)

PRIVACY AND CONFIDENTIALITY STATEMENT

The personal information requested on this form will be used in the determination of your entitlement to, or continued receipt of, Medical Assistance administered by the Indiana Family and Social Services Administration. Disclosure of the information requested is mandatory pursuant to the provisions of IC 12-15 *et seq.* Non-disclosure of the information requested will hamper and possibly prevent the delivery of assistance to you. All personal information collected on and as authorized by this form will be treated as confidential pursuant to 470 IAC 1-2-7, 470 IAC 1-3-1, 42 CFR 431 Subpart F, 45 CFR 164 Subpart E and 42 CFR Part 2.

Unless parties are prohibited from disclosure under federal privacy law, information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected under the HIPAA privacy rule.

NOTICE TO EXAMINING PHYSICIAN

By court order and federal regulation, if the client appeals the decision of the State Medicaid Medical Review Team, this medical information becomes available to the client or his/her legal representative. WARNING: This form does not authorize the release of psychotherapy notes. Furthermore, this form does not authorize the release of mental health records if the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict personal harm or to harm another person.

DETERMINATION OF DISABILITY
Medical Information

Indiana Law [IC 12-14-15-1(2)] requires that, in order to be eligible for Medical Assistance to the Disabled, a person must have a physical or mental impairment, disease, or loss which appears reasonably certain to result in death or that has lasted or appears reasonably certain to last for a continuous period of at least twelve (12) months without significant improvement and which substantially impairs his/her ability to perform labor or services or to engage in a useful occupation. This is not the same definition of disability that is used by the Social Security Administration, or other agencies. The State Medicaid Medical Review Team will make the final disability determination. The records released pursuant to this authorization will be used in making this determination.

PATIENT'S / APPLICANT'S CONSENT FOR RELEASE OF MEDICAL RECORD(S)

Date of birth of patient/applicant (*month, day, year*)	Social Security number of patient/applicant	Case number	Date of consent (*month, day, year*)
	XXX-XX-		

I, _____
First name Middle initial Last name

_____
Address (*number and street, city, state, and ZIP code*)

do hereby authorize _____
Name of person releasing information

_____
Organization releasing information

_____
Address of organization (*number and street, city, state, and ZIP code*)

to release the following medical records:

- Entire medical record for the following dates (*month, day, year*). _____
- Portions of the medical record relating to psychiatric, psychological, or mental health counseling for the dates specified above
- Portions of the medical record relating to alcohol, drug, or other substance abuse treatment for the dates specified above
- Portions of the medical record relating to any communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS); and tests for HIV for the dates specified above

Copies of the records should be furnished to the: Medical Review Team
Office of Medicaid Policy and Planning
402 W. Washington St., Rm. W374, MS07
Indianapolis, IN 46204-2739

I understand that this information is protected under Federal and State confidentiality and privacy regulations and cannot be disclosed without any written authorization unless otherwise provided for in the regulations.

I understand that, pursuant to IC 16-39-1-4, this consent for release of medical and mental health information is subject to revocation by me at any time, except to the extent that action has been taken in reliance on the consent. By law this consent might normally expire sixty (60) days from the consent date listed above; however, I expressly waive this time limit and consent to release of medical and mental health information for one (1) year from the consent date. This consent may be revoked in writing by contacting the county office listed above.

Signature of applicant or legal representative	Date signed (*month, day, year*)
If patient is a minor, signature of parent or legal representative.	Date signed (*month, day, year*)