CONSENT TO RELEASE SOCIAL SECURITY NUMBER

State Form 53190 (R / 10-23)
INDIANA DEPARTMENT OF HEALTH

I hereby give my EXPRESS CONSENT to the Indiana Department of Health to disclose my **Social Security Number** for the below stated purpose:

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Disclosure may be made to the below stated entities:

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I UNDERSTAND THAT WITHOUT MY CONSENT, THE DEPARTMENT MAY RELEASE MY SOCIAL SECURITY NUMBER WHEN EXPRESSLY REQUIRED BY STATE LAW, FEDERAL LAW, OR A COURT ORDER, OR AS OTHERWISE ALLOWED BY INDIANA CODE 4-1-10-5.

I understand that disclosure of the last four (4) digits of my Social Security Number is not a disclosure of my Social Security Number. I understand that this consent may be revoked in writing by submitting a written request to revoke to the Department. I understand that there is a potential that my Social Security Number may be re-disclosed by the recipient. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization if such conditioning is prohibited by the Privacy Rule.

Signature: ____________________________ Witness Signature: ________________________________

Printed Name: _________________________ Witness Name Printed: _____________________________

Date *(month/day/year)* ______________________ Date *(month/day/year)* ______________________

______ **Copy of Identification of individual authorizing release is attached.**

IMPORTANT NOTE: Pursuant to Indiana Code 4-1-10-5 and 10 IAC 5-2-1, only the individual to whom the Social Security Number has been assigned by the Social Security Administration is authorized to grant express consent to release their Social Security Number. A guardian, personal representative, or any other person or agency representing the individual are NOT authorized to provide this type of express consent.

THIS CONSENT EXPIRES _________ DAYS FROM SIGNATURE DATE.