AUTHORIZATION FOR DISCLOSURE OF PERSONAL AND HEALTH INFORMATION - DFR

State Form 54621 (2-11)
FAMILY AND SOCIAL SERVICES ADMINISTRATION / DIVISION OF FAMILY RESOURCES

Purpose

For you to authorize the disclosure of your personal information, which may include health information, to persons or organizations outside of the Division of Family Resources (DFR). Your privacy is protected by state and federal privacy laws. As such, we need your explicit permission to make the requested disclosure. Please complete each section of this form.

Your Name and Identification Information

Name_____

Address_____

City_____ State_____ ZIP Code_____

Telephone (_____)_____ E-mail Address_____

Date of Birth_____ Last 4 Digits of Social Security #_____

What personal information, including health information, are we to disclose?

Please describe the type of information we are allowed to disclose; for example, your contact information, your benefits status, your current eligibility status and/or historical status, or "as requested by the authorized person/organization."[1]

What is the purpose of the requested disclosure of your personal information?

Please describe the purpose for the disclosure (e.g., assistance with obtaining or using FSSA benefits/services, legal assistance, the person is involved in my use of FSSA benefits/services, or simply "at my request").

To whom are we authorized to disclose your personal information?

Please state the names of the individuals or organizations, including contact information.

[1] *If the personal information to be disclosed is identified "as requested by the authorized person/organization", then we will rely on them to identify what information is to be disclosed when receiving their request for disclosure; we will also rely on them to specify the minimum amount of personal information, including health information, that is reasonably necessary to accomplish the purpose of the request.*

Which DFR program areas are you authorizing to disclose your personal information?

❑Medicaid Eligibility ❑Supplemental Nutrition Assistance Program (SNAP)/Food Stamps ❑Child Care Assistance

❑Temporary Assistance for Needy Families (TANF) ❑Other_____

Expiration Date or Event

This authorization will automatically expire sixty (60) calendar days from the date you sign it. You may specify an earlier or later expiration date, or you may specify an event upon which this authorization will expire (e.g., "when my concern has been addressed"). Please select one of the following three:

❑Allow to automatically expire in sixty (60) calendar days ❑Expire on this date (month, day and year): _____

❑Expire on this event: _____

Right to Revoke

You have the right to revoke this authorization at any time. You may revoke this authorization by giving written notice, including e-mail notice, to the DFR contact below. Any disclosures of your personal information, including health information, which we may have made under this authorization prior to revocation will not be affected (they were made while this authorization was still in effect).

Further Disclosure

Once we disclose your personal information, including health information, to the above persons/organizations, the information may no longer be protected under state or federal privacy laws. We cannot control what these persons/organizations do with your information.

Signature

Having had full opportunity to read and consider the contents of this authorization, including my rights and the risks of further disclosure as described above, I am authorizing DFR to disclose my personal information, including health information, to the persons or organizations I have identified above. I understand DFR will disclose only that information which is necessary to accomplish the stated purpose of the disclosure. The information disclosed will be limited to the minimum necessary. I also understand that I am under no obligation to sign this authorization. I also understand that the services and benefits provided to me by or through DFR will not be affected whether or not I sign this form.

Signature_____ Date_____

If this authorization is signed by an individual's personal representative on behalf of the individual, please complete the following:

Personal Representative's Name_____

Contact Information *(include telephone no.)*_____

Relationship to the Individual_____

It is the policy of DFR to verify that an individual's authorized representative is identified as such in our files prior to acting on this authorization.

You will be provided with a copy of this authorization after you sign it.

Contact Information

To revoke this authorization prior to the expiration date or event, contact:

The Division of Family Resources
Attention: Constituent Care Services
402 W. Washington, Room W-392, Indianapolis, IN 46204-2739
E-mail: cc@fssa.in.gov