*DFRHBAE01*

# Authorization For Release of Case Status Information

State Form 53831 (R3 / 10-24) / DFR 2135

## SECTION A: Applicant Information

Applicant/Recipient Name (print): Date of Birth:

Last four digits of applicant's Social Security Number:

Applicant/Recipient Address

City State Zip Code Phone Number

Public Assistance Case Number:

## SECTION B: Entities Authorized to Receive, Use or Disclose

I authorize the release of information to the following Agency/Organization for the purpose of receiving, make use of, and/or disclose the protected information related to the status my Food Stamp, Cash Assistance and/or Health Coverage case on the secured access FSSA Public Assistance Eligibility Internet site (www.ifcem.com). The information contained in the status of your case includes all persons on the case, benefit amounts and dates, scheduled interview appointments, view requests for supporting documents and print a Proof of Eligibility form and will be used for the purpose of attaining the current status of your eligibility case.

Agency/Organization (*Receipt of protected case status information is limited to one health care provider per authorization form)*

Agency/Organization Address

City State Zip Code Agency Phone Number

## SECTION C: Right to Revoke

The agency will have access to your case status information until you request the access be terminated. I understand I may revoke this authorization at any time by giving either written or verbal notice of my revocation by contacting the FSSA Call Center the address and/or telephone number listed below. Additionally, I may also revoke this authorization at any time by giving written permission to agency/organization referenced on this form. I understand that revocation of this authorization will *not* affect any action taken by the agency/organization reference in this form in reliance on this authorization before my written notice of revocation was received.

When you have filled out this form, mail or fax it to:

**Mailing Address:** FSSA Document Center
PO Box 1810
Marion, Indiana 46952

**Fax Number:** 1-888-436-9199

**YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER SIGNING IT**

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## SECTION D: The Applicant or the Patient's Legal Representative Confirming the Authorization

I understand that:

- This authorization is voluntary (you may refuse to sign);
- Health care and payment for my health care will not be affected if I do not sign this form;
- If the agency/organization authorized to receive and/or use the information is not a health plan, health care provider, or health care clearinghouse subject to federal health information privacy laws, the released information may no longer be protected by federal privacy.
- This form ***does not*** extend the right to release/disclose this information to another person, agency or organization outside of the agency/organization authorized in this form.

## SECTION E: Signature

I have had full opportunity to read and consider the contents of this authorization and I confirm that the contents are consistent with my direction to the Agency/Organization listed in this form. I understand that by signing this form I am confirming my authorization that this Agency/Organization may receive, use and/or disclose the protected case status information as described in Sections B and D above.

Applicant Signature or Legal Representative — Date

Witness Signature (If Applicant signs with an 'X') — Date

Agency Representative Signature — Date

## 42 CFR PART 2

This information is from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of other information is not for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER SIGNING IT**