Alabama Medicaid Agency - Permission to Disclose Health Information

Please print all information except signature. Make a copy of the signed form for your records.

**Name of
Recipient:** _____

**Medicaid
ID# or SS#:** _____

Date of Birth: _____/_____/_____
               mm   dd   yyyy

Current Mailing Address: _____

City, State, ZIP _____

I wish to a**uthorize** the disclosure of information to the following person, group of persons or group:

Agency/Representative:_____Telephone: (___)_____

Address: _____

City, State, Zip:_____

The type of information to be disclosed is: _____

_____

The reason for this disclosure of my Protected Health Information is: _____

_____

The expiration date for this authorization is: ____/_____/_____
                                             mm   dd   yyyy

Or when a particular event takes place (List event) _____

I understand that if I do not state an expiration date or event that this authorization will expire one year from the date of my signature.

By signing this form, I give my permission to disclose or release the information stated above from my file or the file of the minor child named on this form for the purpose(s) listed above. I understand that any additional disclosures will require that a complete a new permission form.

I understand that any documents, or records released could potentially be re-disclosed by the above person or class of persons. I also understand that this disclosure of information does not apply to any of my information that is re-disclosed by that party listed above.

I understand that treatment, payment, enrollment or eligibility for benefits does not depend on my signing this form.

I understand that I have a right to revoke (cancel) this authorization at any time. I understand that I must provide you a written request to revoke this authorization. I also understand that any revocation of this authorization shall not affect any disclosures made prior to receipt and processing of my written revocation.

Signature: _____

Date: _____/_____/_____
        mm   dd   yyyy

Requestor Name: _____

Relationship to Recipient: _____