ELIGIBILITY ADVOCATES
The "New Standard" in Patient Eligibility

Consent for Use and Release of Information

I authorize the Department of Human Services (DHS), Social Security Administration, Attorney General/Crime Victims Division, and County Indigent Health Care Services to release information which they may posses concerning my application for those services including:

A) Any detail regarding my status for determination of program
B) Reason for denial or rejection
C) ID, Policy, Certification, and/or Medicaid Number
D) Dates of Eligibility/Coverage
E) Dates of certification of program

I authorize the hospital staff and any third party to obtain any records from any provider, employer, government agency or financial institution (including banks), that have a bearing on my eligibility for assistance.

I authorize the release of the above obtained documents and information for purposes of determining my eligibility for assistance.

I understand this consent allows staff to communicate in person, by telephone or in writing with the above-named entities regarding release of information for assistance. I authorized the hospital to release a medical billing claim on my behalf prior to my approval to ensure the hospital meets the state's timely filing requirements.

I understand that the information requested is protected under federal and state law and cannot be released without my consent. I understand I may revoke this authorization at any time in writing, but if I do; it will not have any effect on any action taken prior to receiving this revocation. This authorization is valid until I qualify for assistance of any of the above-named entities.

I certify that the information provided herein is true and correct. This release of information has been explained to me and consent has been given of my own free will.

_____ _____

Patient/Patient's Representative Signature *Date*

_____ _____

Witness Signature (If above signed by "X") *Date*

_____ _____

Witness Signature (If above signed by "X") *Date*