

Senior Health Insurance Information Program
**AUTHORIZATION TO OBTAIN OR RELEASE HEALTH CARE
INFORMATION FROM DEPT. OF HUMAN SERVICES**

SHIIP has worked with the Department of Human Services to develop a release form which can be used by SHIIP volunteers to secure information from DHS to help clients.

Information Available from DHS

The release form can be used to obtain ONLY the following client information:

- Current Medicaid program(s) (coverage groups) in which enrolled
- Effective date of current enrollments
- Verification that DHS has sent program eligibility information to CMS for Part D low income subsidy eligibility
- Beneficiary's history of program eligibility (Medicaid, QMB, SLMB, QI, Elderly Waiver, nursing home)

Confidentiality

The SHIIP client must sign the SHIIP ***Client Notice*** **and** sign the ***Insurance Information Authorization*** at the bottom of the Client Notice before the DHS Release can be used.

We must protect the privacy of clients' DHS records and must not give information to someone who is not legally entitled to the information. **This is very important.** There are two scenarios where someone other than the client (beneficiary) can sign the release:

1. Clients who are physically or mentally disabled may have an authorized representative's name on file with DHS. This person may complete the release for your client.
2. DHS has also said that if a client signs an authorization for someone else to talk to you about Medicaid and Part D issues, that person can sign the release. You must send the signed authorization with the release. Use the form "Authorization for Release of Information."

Keep a copy of all signed releases with your client records in **a secure location.**

Completing the Form and Submitting to DHS

The following sample form explains how to complete each section. For the form to be valid, an **expiration date must be indicated** following the signature. It can be up to one year from the date the form is signed. Once the form is complete and signed by the appropriate party(ies), you may mail or fax it to the client's caseworker at the county DHS office. FAX numbers are found on pages N15-21 of your SHIIP Handbook or on the DHS web site, www.dhs.state.ia.us . The authorization will be kept on file at the local DHS office until the expiration date. Please keep a copy of the authorization with your client files if you mail the original to DHS.

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**AUTHORIZATION TO OBTAIN OR RELEASE HEALTH CARE
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Client Name:	
ID#:	SS#:
Date of Birth:	Parent/Guardian:

I authorize the following individual or agency to share written and oral information (*two-way or reciprocal release*) about my needs and the services I receive . . .

Name or agency to release and receive information: Department of Human Services County:	
Address:	
City/State/Zip:	
Phone:	Fax:

With the following individual or agency:

Name or agency to release and receive information:	
Address:	
City/State/Zip:	
Phone:	Fax:

The information released or shared may include:

- Receiving phone calls on behalf of client
- Medicaid coverage group in which enrolled
- Effective date
- LIS eligibility sent to CMS
- History of Medicaid coverage

Other (note exceptions or limits to this release):
This information is being used ONLY for (state purpose):

This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. I understand that I have the right to see any information that is disclosed pursuant to this authorization for release. I may request to see this information during normal business hours. I understand that I can revoke my authorization at any time in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall expire on the date specified below. If I fail to specify an expiration date, this authorization will expire in six months after the date it is signed. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Privacy Officer at 800-803-6591. I have read this form, or it has been read and explained to me, and I understand its content.

Authorizing signature:	
Date:	Expiration date:
Relationship to client: <input type="checkbox"/> Self <input type="checkbox"/> Legal representative <input type="checkbox"/> Nearest living relative <input type="checkbox"/> Other (specify below)	

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Client Name: John Doe	
ID#: Medicaid ID #	SS#: 111-222-3333Z
Date of Birth: 1-1-1900	Parent/Guardian: Complete only if client is unable to represent self

I authorize the following individual or agency to share written and oral information (*two-way or reciprocal release*) about my needs and the services I receive . . .

Name or agency to release and receive information: Department of Human Services County: County where client lives	
Address: see N-13-21 of SHIP Handbook	
City/State/Zip:	
Phone:	Fax:

With the following individual or agency:

Name or agency to release and receive information: SHIP Volunteer's Name	
Address: SHIP Volunteer's Address	
City/State/Zip:	
Phone:	Fax:

The information released or shared may include:

- | | |
|---|--|
| Check only
the information
needed to address
current needs | <input type="checkbox"/> Receiving phone calls on behalf of client
<input type="checkbox"/> Medicaid coverage group in which enrolled
<input type="checkbox"/> Effective date
<input type="checkbox"/> LIS eligibility sent to CMS
<input type="checkbox"/> History of Medicaid coverage |
|---|--|

Other (note exceptions or limits to this release):

Client can indicate any exceptions or limits he/she wants to place on your contact with DHS

This information is being used ONLY for (state purpose):

This section is completed by DHS

This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. I understand that I have the right to see any information that is disclosed pursuant to this authorization for release. I may request to see this information during normal business hours. I understand that I can revoke my authorization at any time in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall expire on the date specified below. If I fail to specify an expiration date, this authorization will expire in six months after the date it is signed. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Privacy Officer at 800-803-6591. I have read this form, or it has been read and explained to me, and I understand its content.

Authorizing signature: <i>John Doe</i>	
Date: <i>March 2, 2007</i>	Expiration date: <i>Up to one year from date submitted</i>
Relationship to client: <input checked="" type="checkbox"/> Self <input type="checkbox"/> Legal representative <input type="checkbox"/> Nearest living relative <input type="checkbox"/> Other (specify below)	

**Senior Health Insurance Information Program
Authorization for Release of Information**

I, _____, authorize
_____ to represent me in issues
related to Medicaid and Medicare Prescription drug coverage (Part D). I give
_____ permission to represent
me to Senior Health Insurance Information Program (SHIIP) counselors and
Department of Human Services staff.

Signature of Medicare beneficiary

Date

Telephone Number