AUTHORIZATION TO DISCLOSE INFORMATION TO DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE (DMMA)

Name of Person Whose Records Are to be Disclosed:	
Date of Birth (MM/DD/YYYY):	Social Security Number:

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of the information listed below to Delaware Health and Social Services and/or its Managed Care representatives: AmeriHealth Caritas and United Healthcare Community Plan of Delaware, for determining my eligibility for medical assistance and/or food benefits. This release may be used to ask for, receive and/or release information that is pertinent to my eligibility determination.

All my medical records:

1. All records and other information regarding treatment, hospitalizations, and outpatient care for my impairment(s).
2. Information about how my impairment(s) affect my ability to complete tasks, activities of daily living, and specific functions in the work/school environment.

All Financial records:

1. All records from financial institutions, including information of any accounts closed within the last 60 months.
2. Information from all sources of income (Social Security Administration, current and past employers, Annuity companies, etc).
3. All life insurance companies.

This authorization ends when the information asked for is received, or 12 months from the date signed or until revoked by me in writing, whichever comes first. I understand I may revoke this authorization at any time by notifying the providing organization in writing.

Signature of Individual Authorizing Disclosure:			
If not signed by subject of disclosure, specify basis for authority to sign (provide supporting documentation): ☐ Parent of Minor ☐ Power of Attorney ☐ Guardian ☐ Other			
Date Signed	Address		
Telephone Number:	City	State	Zip Code

You are not required to sign this form as a condition of eligibility and your health care and payment for health care will not be affected if you do not sign this form. However, you will still be required to provide the necessary information to DMMA in order for us to be able to determine your eligibility for Medicaid.

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and therefore no longer protected by Federal privacy laws.