Clear Form

Minnesota Department of **Human Services**

DHS-6124-ENG 7-16

State Medical Review Team

Authorization to Release Protected Health Information

Read the entire form before signing.

PMI # _____

PATIENT NAME (First, Middle, Last)	PHONE NUMBER	DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY NUMBER

Signing this form authorizes these sources:

- All my health care providers (hospitals, clinics, labs, physicians, psychologists, etc.), including mental health, correctional, addiction treatment, and VA facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers and rehabilitation counselors
- Others who know about my condition (family, insurance companies, public officials)

This authorization authorizes disclosure by **all** medical sources. Authorization specifically naming each health care provider is not required. One authorization may be used to authorize disclosures by categories of covered entities without naming particular covered entities as allowed under 45 Code of Federal Regulations (CFR), section 164.508(c)(1)(ii).

To release this information:

- All records and information about my treatment, hospitalization, and outpatient care for my impairment(s), including records and information about the following:
  - o Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR, section 164.501)
  - o Drug abuse, alcoholism, or other substance abuse
  - o Sickle cell anemia
  - o The presence of a communicable or noncommunicable disease
  - o HIV or AIDS (including test results)
  - o Gene-related impairments (including genetic test results)
- Information about how my impairment or impairments affect my ability to work and complete tasks and activities of daily living
- Copies of educational tests or evaluations, including individualized educational programs, team assessments, psychological and speech evaluations, and any other records that can help evaluate functions, including observations

For these dates of treatment: Any date of treatment occurring within 12 months of the date I signed this form, as well as past dates of treatment

To the following: The State Medical Review Team (SMRT), medical reviewers and providers who perform requested exams, and the county agency authorized to process my case

For this purpose: To determine whether I meet Social Security disability criteria and am eligible for Medical Assistance or other state programs

- This authorization automatically expires 12 months from the date I sign this form.
- I authorize the use of a written or electronic copy of this form for the disclosure of the information described above.
- I understand that once information is released, it may be redisclosed to another third party and no longer protected.
- I may write to SMRT, my county, or my providers and other sources information to revoke this authorization at any time.
- SMRT will give me a copy of this form if I ask; I may ask a source of information to let me inspect or get a copy of material to be disclosed.
- I understand that I may refuse to sign this form and that a source of medical information may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form.

I have read both pages of this form and agree to the disclosures above from the types of sources listed.

PERSON AUTHORIZING DISCLOSURE Sign Here ➤			DATE SIGNED
STREET ADDRESS	CITY	STATE	ZIP CODE

IF NOT SIGNED BY THE PATIENT, AUTHORIZED PERSON'S AUTHORITY TO SIGN

◯ Parent of child under age 18 ◯ Guardian (send court order) ◯ Power of attorney (send notarized form) ◯ Deceased (send death certificate)

If the person authorizing the disclosure signs with an X, then two witnesses must also sign below. If the person authorizing the disclosure is incarcerated, then one witness must sign below.

WITNESS Sign Here ➤	**SECOND WITNESS** Sign Here ➤

Explanation of This Form

We need your written authorization to help get the information required to determine disability. Laws and regulations require that sources of personal information have a signed authorization before releasing that information to us. Also, laws require specific authorization for educational sources to release information about certain conditions.

You can provide this authorization by signing this form. Federal law permits sources with information about you to release the information if you sign a single authorization to release all your information from all your possible sources. We will make a copy of the authorization for each source. A covered entity (a source of information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke the authorization, send a written statement to the State Medical Review Team (SMRT). If you revoke the authorization, also send a copy of the written statement directly to each source that you no longer wish to disclose information about you. SMRT can tell you whether we identified any sources you did not tell us about. SMRT may use any information disclosed before revocation to decide your claim.

Important Information, Including Notice Required by the Privacy Act

All personal information collected by SMRT is protected by the Privacy Act of 1974. Once medical information is disclosed to SMRT, it is no longer protected by the health information privacy provision of 45 CFR, part 164, mandated by the Health Insurance Portability and Accountability Act (HIPAA).

Signing this form is voluntary, but failing to sign it, or revoking it before we get the necessary information, could prevent an accurate and timely decision about your disability certification and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, SMRT may disclose the information without your consent if authorized by federal or state laws such as the Privacy Act. For example, SMRT may disclose information for these reasons:

- To enable a third party (for example, consulting physicians) or other government agency to help SMRT establish benefits, coverage, or both
- For statistical research and audit activities necessary to ensure the integrity and improvement of the SMRT program

SMRT will not redisclose, without proper prior written consent, information (1) about alcohol or drug abuse as covered in 42 CFR, part 2; (2) from a minor's educational records obtained under 34 CFR, part 99 (Family Educational Rights and Privacy Act [FERPA]); or (3) about mental health, developmental disability, AIDS or HIV.

SMRT may also use the information you give us when we match records by computer. Matching programs compare our records with those of other federal, state and local government agencies. Many agencies use matching programs to find or prove that a person qualifies for benefits paid by the federal government. The law allows us to do this even if you do not agree to it.

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកការងារសង្គមរបស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກ່ຽວກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1-0001 (3-13)

ADA1 (9-15)

ADA Advisory

For accessible formats of this publication or assistance with additional equal access to human services, write to DHS.SMRT@state.mn.us, call 800-235-7396, or use your preferred relay service.