Authorization to Release Information
Personal Physician, Hospital or Clinic

Claimant Name:	
Social Security Number:	Date of Birth:

Provider Name:
Address:
Telephone Number:
Dates of Service:

I hereby authorize the above named provider to release to the local Department of Social Services and the State Review Team all health information concerning me, including records, test results and medical history.

This information is requested for the purposes of making a disability determination.

I understand that the information may include, but is not limited to, treatment, hospitalization or outpatient care for behavioral, mental or physical illness, counseling or treatment for drug or alcohol abuse, human immunodeficiency virus (HIV) infection or acquired immunodeficiency syndrome test results or gene related impairments (including genetic testing).

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. However, I understand that if I refuse to sign this form, the State Review Team may not be able to obtain sufficient information to determine whether I am disabled.

I understand that authorizing the disclosure of information carries with it potential for unauthorized re-disclosure but that the local Department of Social Services and State Review Team are prohibited from re-disclosing the requested information except to authorized persons as permitted by State law.

I understand that I have the right to revoke this authorization in writing at any time. Otherwise, this authorization is valid for one year from the date of signature or until closure of my case with the local Department of Social Services, whichever occurs first. I understand the revocation will not apply to information that has already been released in response to this authorization.

I authorize use of a copy (including an electronic or faxed copy) of this form for the disclosure of the information described above. I have read this form in its entirety and agree to the disclosures above from the types of sources listed.

Signature of Claimant _____ Date _____

(If Signed by Legal Representative, Relationship to Patient) _____ Date _____