MARYLAND MEDICAL ASSISTANCE PROGRAM

CONSENT TO RELEASE INFORMATION

(To be used by the Long-term Care Facility when releasing newly received information to the Local Department of Social Services including income/assets)

As an applicant/recipient of Medical Assistance, I authorize the release to the Department of Health and Mental Hygiene (The Department) and/or its delegate agencies all data, records, and information by insurance companies, non-profit health service plans, providers of medical care, employers, agencies or organizations necessary for The Department's pursuit of third party reimbursement or verification of my statements provided in this application. I understand that this signed statement serves as written authorization for any of the above persons, agencies, or organizations to release the information requested.

The social security number of every Medical Assistance applicant/recipient will be used to obtain and verify information concerning his/her unearned income, cash benefits, wages and resources. I give my consent for The Department and/or its delegate agencies to compare the information I have given with the records of Federal, State, Local, and private agencies or businesses.

_____

Signature of Applicant/Recipient/Representative

_____ _____

Social Security Number of Applicant/Recipient CID #

_____

Date

This form is valid for 12 months from the date of signature

NOTICE TO MEDICAID APPLICANTS

You are providing personal information (Name, Address, Date of Birth, Income History, Employment History, etc.) in this application for Medicaid benefits.

The purpose of requesting this personal information is to determine your eligibility for Medicaid. If you do not provide this personal information, the Medicaid Program may deny your application of benefits. You have a right to inspect, amend, or correct this personal information. The Medicaid Program will not permit inspection of your personal information, or make it available to others, except as permitted by federal and state law.