DEPARTMENT OF HUMAN RESOURCES
F^MILY INVESTMENT ADMINISTRATION
W. Saratoga Street
,imore, Maryland 21201

F I A INFORMATION MEMO

EFFECTIVE DATE: Upon Receipt

ISSUANCE DATE: June 27, 1996

CONTROL NUMBER: FIA OPA #97-01

TO: Directors, Local Departments of Social Services
Deputy/Assistant Directors For Family Investment
Family Investment Supervisors

FROM: Kevin Mahon, Executive Director, FIA

RE: New Release of Information Form

ORIGINATING OFFICE: OPA/Policy and Regulations

Freestate Health Plan, a Blue Cross/Blue Shield of Maryland HMO, will soon begin using a new form (Authorization of Release For Current Freestate Medicaid Members) developed exclusively for local departments of social services. The information will be used by Freestate to provide services under the Medical Assistance program. DHR's Office of the Attorney General assisted in its development and has approved the final version.

The purpose of this memo is to introduce the new authorization for release of information form (copy attached) and advise you to honor future requests for information from Freestate Health Plan submitted on this form. Customer information that may be provided is limited to:

- Current address/phone number
- Social Security number
- Date(s) of birth
- Medical Assistance number
- MA recon date/eligibility status
- Name/phone number of assigned LDSS worker

Questions may be directed to Yvonne Batson at (410) 767-7733.

KM:ywb

cc: DHR Executive Staff
FIA Management Staff
Arnold Dixon

FREESTATE HEALTH PLAN

An Independent Licensee of the Blue Cross and Blue Shield Association

AUTHORIZATION OF RELEASE FOR CURRENT FREESTATE MEDICAID MEMBERS DEPARTMENT OF SOCIAL SERVICE INFORMATION RELEASE

I, ______________________ on_______19___, authorize the Department of Social Services
(Legal Representative Giving Authorization)
(DSS) Case Worker or a representative from the ______________________ DSS to release
(Local Department)
information regarding the person(s) listed below to FreeState Health Plan in order to assist with maintaining Medical Assistance Benefits and provide services offered through the Medical Assistance program. This authorization will be in effect from __________ to __________.

This is limited to the following information:

- Social Security number
- Date or dates of birth
- Medical Assistance number
- Eligibility status with Medical Assistance (reconsideration date)
- Current address and phone number
- DSS Case Worker's name

As the parent, guardian, or attorney for the person(s) listed below, I authorize the above information to be released to assist these members.

Name: ________________________ Relationship: ________________ SS# ____________
Name: ________________________ Relationship: ________________ SS# ____________
Name: ________________________ Relationship: ________________ SS# ____________
Name: ________________________ Relationship: ________________ SS# ____________

I understand that any and all information released to FreeState Health Plan will be considered confidential information and used solely for assisting me with the recertification process and to assist me with obtaining other services available through DSS and any other appropriate programs. I also understand that I may cancel this authorization in writing at any time.

________________________ Signature: ____________________ Date: __________
Adult Member's Name (Print) Social Security # ____________________

________________________ Signature: ____________________ Date: __________
Adult Member's Name (Print) Social Security # ____________________

I solemnly declare and affirm under the penalties of perjury that the above information is true and correct. ______________________________.
Member or Members Name (Print)

________________________ Signature: ____________________ Date: __________
Witness Name (Print)
Social Security # : ____________________

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