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

I, _____________________________, authorize the Department of Social Services
(Legal Representative (living Authorization))
(DSS) Case Worker or a representative from the _____________________________ DSS to release
(Legal 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 of 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 Member's Name (Print) Signature: ___________________________ Date: ____________
Witness Name (Print) Social Security #: _____________________________