ATTACHMENT
SAMPLE OF A COMPLETED FORM

WHOSE Record to be Disclosed	
Name (First, Middle, Last) **Jane Jean Doe**	
SSN 222-33-4444	Birthday (01/01/1959)

AUTHORIZATION TO DISCLOSE INFORMATION TO
THE DEPARTMENT OF HUMAN RESOURCES (DHR) FAMILY INVESTMENT ADMINISTRATION (FIA)
STATE REVIEW TEAM (SRT)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to**:**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of communicable or venereal diseases which may include, but are not limited to, Acquired Immune Deficiency Syndrome (AIDS): and tests for HIV.
   - Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Programs (IEP), triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM
- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by FIA
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SRT Additional information to identify the subject (e.g., other names used) the specific sources, or the material to be disclosed:

TO WHOM **The Department of Human Resources and to the State agency authorized to process my case** (usually called "Family Investment Administration"), **including contract copy services, and doctors or other professionals consulted during the process**

PURPOSE Determining my eligibility for benefits, including looking at the combined effect of any Impairments that by themselves would not meet the definition of disability.

EXPIRES WHEN This authorization is good for 12 months from the date signed that appears below.
- I authorize the use of a copy (including electronic copy) of this form for disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to FIA and my sources to revoke this authorization at any time (see page 2 for details).
- FIA will give me a copy of this form if I ask: I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed**.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY **INDIVIDUAL authorizing disclosure** **SIGN** ➡ Jane Doe		**IF not signed by subject of disclosure, specify basis for authority to sign** ☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain) **SIGN HERE:**	
Date Signed 5/10/09	Street **Address** **545 South Street**		
Phone Number (with area code) **410-555-9999**	City **Baltimore**	State Maryland	Zip 21245
WITNESS I know the person signing this form or am satisfied of this person's identity: **SIGN** ➡ **(OPTIONAL)**			
Phone Number (or Address)			

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L 104-191 ("HIPAA") 45 CFR parts 160 and 164.42 U.S Code section 290dd-2: 42 CFR part 2; 38 U.S. Code section 7332, 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; Md. Code Ann., Human Services Art. §1-201, Health-General Art.§§4-302-03 and 4-307.

Explanation of Form DHR/FIA 827,

"Authorization to Disclose Information to the State Review Team"

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

You can provide this authorization by signing a form DHR/FIA 827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. Some individual sources of information require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

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, send a written statement to your local department of social service office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you. FIA can tell you if we identified any sources you didn't tell us about. FIA may use information disclosed prior to revocation to determine your eligibility for benefits.

IMPORTANT INFORMATION REGARDING CONFIDENTIALITY

All personal information collected by FIA is protected by Maryland law, including Md. Code Ann., Human Services Art. § 1-201, as well as federal law. Once medical information is disclosed to FIA, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). FIA retains personal information in strict adherence to the retention schedules established and maintained as required by Md. Code Ann., State Gov't Art. § 10-611 *et seq*.

The State of Maryland, through DHR/FIA, is authorized to collect the information on form DHR/FIA-827 by section 1902 of the Social Security Act, which sets forth the requirements for states administering the Medical Assistance program. We use the information obtained with this form to determine your eligibility, or continuing eligibility, for benefits. This usually includes review of the information by the State agency processing your case and quality control people in DHR. In some cases, your information may also be reviewed by DHR personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your application, and could result in denial or loss of benefits. Although the information we obtain with the form is almost never used for any purpose other than those stated above, the information may be disclosed by DHR without your consent if authorized by Federal and State laws. For example, DHR may disclose information:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist DHR to establish rights to benefits and/or coverage;
2. Pursuant to law authorizing the release of information from DHR records;
3. For statistical research and audit activities necessary to ensure the integrity and improvement of DHR programs.

DHR will not redisclose without proper prior written consent information: (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, (2) from educational records for a minor obtained under 34 CFR part 99, Family Educational Rights and Privacy Act (FERPA), or (3) regarding mental health, developmental disability, AIDS or HIV.

We 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, or local government agencies. Many agencies may 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.