covering kids & families

LEGAL AID SOCIETY CHIPRA PROJECT CONSENT FORM

I, _____,
the undersigned hereby authorize, the Legal Aid Society of Greater Cincinnati / Legal Aid Society of Southwest Ohio and HealthSource of Ohio to obtain confidential information about me or any child of whom I am the parent or guardian for purpose of obtaining Medicaid for myself or any child of whom I am parent or guardian. This information may include personal health information as defined below.

I authorize the Ohio Department of Job and Family Services and the U.S. Department of Health and Human Services to disclose confidential information, including personal health information, concerning me or any child of whom I am the parent or guardian.

Additionally, I authorize the following entities to disclose confidential information, including personal health information, concerning me or any child of whom I am the parent or guardian.

☐ My Employer:_____

☐ The School of my Child:_____

☐ Other:_____

Personal Health Information includes individually identifiable information that may include all information in a medical record, results of physical examinations, medical history, lab tests, or certain health information indicating or relating to a particular condition. This authorization includes , release of information concerning testing of HIV, AIDS, AIDS –related conditions , drug or alcohol abuse , drug related conditions, alcoholism, and / or psychiatric /psychological conditions.

Redisclosure: I understand that the information used and / or disclosed pursuant to this Consent may be re-disclosed by the recipient of the information and may no longer be protected by Federal law.

Expiration: This Consent will expire on September 30, 2011, the end date of the Legal Aid CHIPRA Medicaid Enrollment and Retention project funded by the U.S. Department Health and Human Services.

Revocation: I understand that I may revoke this Consent at any time by notifying the Legal Aid Society of Greater Cincinnati / Legal Aid Society of Southwest Ohio and / or HealthSource of Ohio in writing.

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the use or disclosure of my individually identifiable health information to the purpose and extent stated.

_____ _____
NAME DATE OF SIGNATURE

_____ _____
SOCIAL SECURITY NUMBER DATE OF BIRTH