MEDICAID NON-EMERGENCY MEDICAL TRAVEL

Authorization for the Use or Disclosure Of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, as amended, the South Dakota Department of Social Services, Medicaid Non-Emergency Medical Travel (NEMT) Program may not use or disclose your personally identifiable health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and return it to the Department.

Section 1: (Patient Information)

I,

Patient/Participant Name: ____

Address: ____

City: ____________________ State: ______________ Zip Code: ______________

Date of Birth: ______________ Phone #: ______________ Recipient ID #: ______________

hereby authorize the Department of Social Services, Medicaid Non-Emergency Medical Travel Program to release the information described in Section 2 of this Authorization, to the persons, entities or classes of persons or entities listed in Section 3 of this Authorization.

Section 2: Information Requested

Specific information requested: All records related to the treatment or payment of healthcare services.

Specific dates of service for the information requested: All dates of services for the term of this authorization until revoked or terminated as set forth in Section 4.

Purpose of the disclosure: To facilitate services and payment through the **Medicaid Non-Emergency Medical Travel Program**.

Section 3: Recipient Information

The specified information is to be released to the following persons, entities or classes of persons or entities:

______________________________________.

Section 4: Disclosures

I understand the information received may include information relating to drug and/or alcohol abuse or physical/sexual abuse. The South Dakota Department of Social Services, its employees, officers, and medical providers are hereby released from any legal responsibility or liability for release of the above information to the extent indicated and authorized herein.

As stated in the Department's Notice of Privacy Policies, this Authorization form may be revoked at any time except to the extent the staff has taken action upon it. If not revoked, this Authorization to release protected health information will terminate in **five (5) years from the date listed in Section 5 of this form** or upon the following specified date: _________________. I understand that this authorization may be revoked at any time, as long as I do so in writing.

I understand if this information is released to a third party, the information may be released by the person or entity that receives the information and may no longer be protected by federal or other applicable privacy regulations. Exception -- drug and/or alcohol treatment information, HIV testing information, and mental health treatment information may not be re-disclosed without my specific consent.

I understand that I am under no obligation to sign this authorization. If the information requested is necessary to determine if I am eligible to enroll in benefits available through the South Dakota Department of Social Services or to determine if another medical program can pay for my health care, I understand that if I choose not to authorize the disclosure and use of this information, I may not be able to show that I qualify. If the South Dakota Department of Social Services has been asked to allow or pay for a health care service on my behalf (such as a test or evaluation) for the purpose of providing the results of those services to someone else, I understand that if I choose not to authorize the disclosure of that information to the other person, the Department of Social Services may not allow the service or the payment for the services provided on my behalf.

Section 5: Signatures

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Signature of participant/patient, parent, guardian, or authorized representative giving consent — Date

____

Print Name — Relationship to Participant/Patient

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If signed by a personal representative, provide a description of the representative's authority to act for the participant/patient.

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Telephone number of the participant/patient, parent, guardian, or authorized representative for verification of the request for information

REVOCATION OF AUTHORIZATION

I hereby cancel this request to release information effective immediately:

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Signature — Date