Ohio Department of Job and Family Services (ODJFS)

AUTHORIZATION FOR THE RELEASE OR USE OF PROTECTED HEALTH INFORMATION (PHI)

FOR STATE USE ONLY	
Tracking #	
Date Received	
Approved / Denied By and Date	

SECTION A:

Name: X	**Address:** X
Billing Number:	X
Social Security Number: (Optional--see reverse side)	X

I, X _____ (Name of Individual), hereby authorize X _____ (Name of covered entity, such as "ODJFS") to disclose protected health information to Crawford County Job & Family Services (Who will receive the information?) for the purpose of verification of medical information

_____ (Describe why this information is being released)

Information is to be mailed to: Street 225 East Mary Street City Bucyrus State OH Zipcode 44820

Is this information being released for an insurance claim? ✓ NO _____ YES **(If YES, see Section II on reverse side.)**

SECTION B:

The specific protected health information to be released is: Verification of attendance of medical appointment(s)

_____ (What information should be released?)

SECTION C: By signing below, I understand that:

- This authorization shall expire on December 31, 2012 (Date or completion of "event") or until revoked by me in writing, whichever comes first.
- I have the right to revoke or cancel this authorization at any time by providing notice in writing to: Ohio Department of Job and Family Services, Attn: Health Information Privacy Official, P.O. Box 182825, Columbus, Ohio 43218-2825.
- If I revoke or cancel this authorization, it is not effective for the use or for the disclosure of my protected health information that has already occurred.
- Any information used or disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it may no longer be protected by federal or state law.
- I am not required to sign this authorization. If I refuse to sign this form, it will not affect my Medicaid eligibility, my eligibility for other programs such as Disability Assistance Medical, Refugee Medical, or Healthy Start Healthy Families or my application for such programs.
- I have a right to inspect or copy the protected health information that will be used or disclosed as per this authorization.
- If by law we cannot send the protected health information to the entity listed above, please initial in the following space if you want a copy of the information sent to you directly:_____.

SECTION D:

Signature of Individual or Authorized Representative	Print name of individual
X	X
Representative's legal authority to individual	Print name of Authorized Representative

X Today's Date:

Distribution: Send completed form to the Ohio Department of Job and Family Services, Attn: Health Information Privacy Official, P.O. Box 182825, Columbus, Ohio 43218-2825. Photocopy must be given to individual or individuals authorized representative.

***** Important information and instructions for completing this form are on the reverse side.*****

JFS 03397 (07/2003)