

THE PURPOSE OF THE DISCLOSURE – PROVIDE A DESCRIPTION OF THE PURPOSE OF INTENDED USE AND DISCLOSURE

_____ I understand and agree to have my health care provider complete and return ABP 1676-1 form to Department of Public Social Services (DPSS) so they can determine my eligibility to receive benefits.

I understand that health information used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive a Copy of This Authorization – I understand that if I sign this authorization, I will be provided with a signed copy of the form.

CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment from my health care provider but doing so may impact my eligibility to receive DPSS benefits.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient/Legal Representative Print Name Date

If signed by other than the patient, state relationship and authority to do so:

_____ Date: ____/____/____

Witness: _____ Print Name _____

Right to Revoke This Authorization – I understand that I have the right to revoke this Authorization at any time by telling DPSS in writing. I may use the Revocation of Authorization at the bottom of this form. Mail or deliver the revocation to the following address:

I also understand that a revocation will not affect the ability of DPSS or any health care provider to use or disclose the health information or reasons related to the prior reliance on this Authorization.

<u>REVOCAION OF AUTHORIZATION</u>	
Signature of Patient/Legal Representative:	Date:

If signed by other than patient, state relationship and authority to do so:	
