W-298
(Rev. 1/11)

STATE OF CONNECTICUT – DEPARTMENT OF SOCIAL SERVICES

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

In order for the Department of Social Services (DSS) to use or disclose information it has about you in its records for a purpose that is not directly related to administration of its programs or not required by law or court order, you must complete and sign this form. Your record may include protected health information (PHI) relating to your past, present or future health condition; the provision of health care; or the past, present or future payment for the provision of health care.

Name of DSS Client: _____

I authorize DSS to disclose the information indicated below to: (name and address of person to receive information)

Lien Resolution Group

55 Old Nyack Turnpike Rd, Ste 311, Nanuet, NY 10954

for the following purpose(s):

To substantiate Medicaid's lien relating to a lawsuit

(If you do not wish to state a purpose, you may write "at my request.")

Type of Information DSS is Authorized to Disclose (check those that apply):

☐ PHI* ☐ alcohol and/or drug treatment records** ☐ HIV related information*** ☐ financial

☐ DSS application and documentation relating to benefits received or receiving ☐ all information in record

☐ records maintained by the Bureau of Rehabilitation Services (BRS) ☐ other _____

- I understand that my refusal to sign will not affect my ability to obtain services or benefits from DSS.
- I understand that I may revoke this authorization at any time by notifying DSS, in writing, except if a disclosure has already been made in reliance on it.
- I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by privacy regulations.

This authorization expires on _____ (date) or upon _____ (event). (If use or disclosure of PHI is for research, including the creation and maintenance of a database, write "end of research study" or "none.")

_____ _____ _____

Signature of Individual or Legal Representative (If a Legal Representative, attach copy of designation) | ID # or S.S. # of Individual | Date

_____

Printed Name of Person Who Signed

Note to Recipient of Information:

* The confidentiality of psychiatric records is required under chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.

** **Alcohol and/or Drug Treatment Records:** This information has been disclosed to you from records protected by Federal confidentiality rule (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise, permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

*** **HIV Related Information:** This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.