DOUGLAS C. WILSON, CPA, CIG
INSPECTOR GENERAL

OFFICE OF INSPECTOR GENERAL

AUTHORIZATION FOR USE AND RELEASE OF HEALTH INFORMATION

SECTION I

Name_____ D.O.B._____

Medicaid ID# (if known) _____ SSN#_____

By signing this authorization form, you are giving the Texas Health and Human Services Commission (HHSC) permission to release all or part of your Medicaid claims history, which includes health information.

SECTION II – To be completed by Client

I authorize HHSC to release the information indicated in Part A below to the person or agency named in Part A below, for the purpose(s) stated in Part B below. My information will remain available to the person or agency indicated until the expiration date stated in Part B.

Part A – Release of information: I understand that my Medicaid claims history contains protected health information.

Check one of the following:

- ☐ Release all of my Medicaid claims history
- ☐ Release only the parts of my Medicaid claims history that relate to:
  - ○ the following health care provider: _____
  - ○ other (please describe in detail the health information you authorize HHSC to release):

_____
_____

Release my information to the following Person/Agency: The Lien Resolution Group
55 Old Nyack Turnpike Rd. Ste 311 Nanuet, NY 10954

Part B - Purpose(s) of Release: To substantiate Medicaid's lien relating to a lawsuit

This authorization expires on: _____

Part C - Signature: _____ Date: _____
(Client or Personal Representative's Signature)

If you are signing for the client, please describe your authority to act for the client on the following line:
_____

Note: If the person requesting the release of my Medicaid claims history cannot sign his/her name, a witness to his/her mark (X) must sign below:

_____ _____
Witness Date:

SECTION III – Notices to Client

O Once you authorize HHSC to release your information, HHSC is not responsible for any redisclosure of the information by the recipient.

O You can withdraw permission you have given HHSC to use or disclose health information that identifies you, unless HHSC has already taken action based on your permission. You must withdraw your permission in writing.

O With a few exceptions, you have the right to request and be informed about the information that the Health and Human Services Commission (HHSC) releases. You are entitled to receive and review the information upon request. You also have the right to ask HHSC to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). If you would like HHSC to correct information about you that is incorrect, please contact the HHSC Privacy Office at 4900 N. Lamar Blvd., 4th Floor, Austin, Texas 78751.