

**COMMONWEALTH OF VIRGINIA  
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)  
GENERAL CONSENT FOR RELEASE OF INFORMATION**

Provider or Enrollee Name: \_\_\_\_\_ Provider ID or Medicaid ID # or Social Security # \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ (month/day/year)

**PERMISSION FOR DMAS TO RELEASE INFORMATION:**

I hereby give the Department of Medical Assistance Services permission to release to  
Lien Resolution Group the following information:  
(INDIVIDUAL/ORGANIZATION/PLACE OF BUSINESS)

\_\_\_\_\_ Medical \_\_\_\_\_ Psychiatric \_\_\_\_\_ Financial \_\_\_\_\_ Medical claims history\* \_\_\_\_\_ Other (Explain below)  
**(INITIAL LINE TO THE LEFT OF EACH ITEM DESIGNATED)**

\*Specify time period for Medical claims history which contains services billed to and paid by DMAS

**PERMISSION FOR DMAS TO OBTAIN INFORMATION:**

I hereby give the Department of Medical Assistance Services permission to obtain from  
Lien Resolution Group the following information:  
(INDIVIDUAL/ORGANIZATION/PLACE OF BUSINESS)

\_\_\_\_\_ Medical \_\_\_\_\_ Psychiatric \_\_\_\_\_ Financial \_\_\_\_\_ Other (Explain below)  
**(INITIAL LINE TO THE LEFT OF EACH ITEM DESIGNATED)**

**This consent is good until \_\_\_\_\_ (Date)**

I understand that I can withdraw this consent at any time by contacting DMAS at the address below.

I understand that DMAS will take reasonable steps in accordance with State and Federal law to safeguard the confidentiality of my medical and personal records. Medicaid is subject to the confidentiality restrictions set forth in 42 CFR 431.300 through 431.307, Virginia Code §32.1-325.4, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Virginia Administrative Code 30-20-90. I also understand that under the Virginia Privacy Act of 1974, I have the right to inspect, correct, or complete this information.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Enrollee/Provider

If not signing for self (above), state relationship to client, such as: parent of minor, power of attorney, legal guardian or other legally authorized representative. Must provide a copy of court or legal documents.

Relationship: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Witness if signed by mark

This Release form was acknowledged before me this \_\_\_\_\_ day \_\_\_\_\_, 20 \_\_\_\_\_

NOTARY PUBLIC \_\_\_\_\_ My commission expires \_\_\_\_\_

This form contains patient-identifiable information and is intended for review and use by no one except authorized parties. Misuse or disclosure of this information is prohibited by State and Federal laws. If you have obtained this form by mistake, please send it to the address below.

**INSTRUCTIONS: The enrollee or provider granting the release must initial the line to the left of each box checked. Return the original to DMAS after making a copy for your files. Mail the original form to:**

**Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219**