Ohio Department of Medicaid

Authorization for the Release or Use of Protected Health Information

SECTION A:

Name		Medicaid ID/Case Number	
Address	City	State	Zip Code

I, _____ (*Name of Individual*), hereby authorize ODM (*Name of covered entity, such as "ODM"*) to disclose Protected Health information to CD SERVICES INC (*Who will receive the information?*) for the purpose of LITIGATION DISCOVERY (*Statement of the purpose for this release or disclosure*)

The information is to be sent to: CD SERVICES INC			
Street 24027 RESEARCH DRIVE	City FARMINGTON HILLS	State MI	Zip Code 48335

Section B:

The specific information to be released is:

ALL RECORDS AS KEPT IN YOUR SYSTEM REQARDING MYSELF

SECTION C:

By signing below, I understand that:

- This authorization shall expire on _____ (*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 the Ohio Department of Medicaid, Attn: Health Information Privacy Official, P.O. Box 182709, Columbus, OH 43218-2709.
- If I revoke or cancel this authorization, it is not effective for the use or for the disclosure of my 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 from disclosure by federal or state law.
- I understand that my receipt of treatment, the payment for my treatment, and my enrollment or eligibility for benefits or services is not conditioned on signing this authorization unless the authorization is necessary for determining eligibility for the program or enrollment in the program.
- I have a right to inspect or copy the information that will be used or disclosed as per this authorization.
- I understand that in the event my records contain psychotherapy notes, a separate authorization may be required for the psychotherapy notes.
- I understand that this authorization permits the use and/or disclosure of information related to HIV testing or the treatment of AIDS or AIDS related conditions, drug or alcohol abuse, psychiatric conditions (excluding psychotherapy notes) unless excluded in Section B.

Signature of Individual or Representative	Print Name of Individual	Date
Representative's Authority to Act for Individual	Print Name of Representative	Date

Distribution: Send completed form to the Ohio Department of Medicaid, P.O. Box 182709 Columbus, Ohio 43218-2709

CDSJOB#_____