Clear

AUTHORIZATION TO DISCLOSE INFORMATION

Whose Records are to be Disclosed (print name):	SSN:_____
_____ First _____ Middle _____ Last	Date of Birth: _____ Month Day Year

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of all my medical records, education records, and other information related to my ability to perform tasks.

This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s), including but not limited to:
   - Psychological, psychiatric or other mental impairment(s) (excludes psychotherapy notes as defined in 45 CFR 164.501).
   - Drug abuse, alcoholism, or other substance abuse.
   - Sickle cell anemia.
   - Gene-related impairments, including genetic test results.
2. Records which may indicate the presence of communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS) and tests for HIV.
3. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and my ability to work.
4. Information created within 12 months after the date this authorization is signed, as well as any and all past information.

This authorization allows for release of information FROM:

- All medical sources (hospitals, clinic, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities.
- All educational sources (schools, teachers, records administrators, counselors, etc.).
- Social workers/rehabilitation counselors.
- Consulting examiners used by DCF or DDD.
- Employers.
- Others who may know about my condition (family, neighbors, friends, public officials).

This authorization allows for release of information TO:

- The Department of Children and Families,
- The Division of Disability Determinations, including contract copy services and doctors, and
- Other professionals consulted during the disability evaluation process.

The **PURPOSE** of this authorization is to obtain information that may be used to determine my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet the SSA definition of disability used by DCF.

EXPLANATION OF CF-ES Form 2514: We need your written authorization to help get the information required to process your Medicaid application. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources. You can provide this authorization by signing a form CF-ES 2514. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

IMPORTANT INFORMATION ABOUT PRIVACY: Personal information collected by DCF or DDD is protected by Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). DCF maintains records in accordance with policies contained in CFOP 15-4.

SIGNING THIS FORM IS VOLUNTARY, but failing to sign or revoking it before we receive necessary information could prevent an accurate or timely decision on your Medicaid application, and could result in a denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by DCF without your consent if authorized by Federal Laws such as the Privacy Act. For example, DCF may disclose information:

- To enable a third party (e.g., consulting physician) or other government agency to help DCF establish rights to disability benefits and/or coverage.
- Pursuant to law authorizing the release of information from DCF records (e.g., to the Inspector General, Federal or State benefit agencies or auditors, or the Department of Veterans Affairs).
- For statistical research and audit activities necessary to ensure the integrity and improvement of DCF programs.

DCF will not redisclose information without proper prior written consent, information relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or from educational records for a minor obtained under 34 CFR part 99 (FERPA), or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about possible reasons why information you provide us may be used or given out are available upon request from any DCF office.

This authorization EXPIRES 12 months from the date it is signed (date below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see details above).
- I may write to DCF and my sources to revoke this authorization at any time. I understand that information collected prior to the revocation will be used to determine if I am disabled.
- DCF will give me a copy of this form if I ask. I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read this form in its entirely and agree to the disclosures above from the types of sources listed.

Please sign using blue or black ink. SIGN ►	If not signed by subject of disclosure, specify basis for authority to sign: ☐ Parent of minor ☐ Guardian ☐ Power of Attorney ☐ Other (specify):

Date Signed:	Street Address:		
Phone Number (with area code)	City	State Florida	Zip Code

WITNESSES: *I know the person signing this form or am satisfied of this person's identity (REQUIRED IF individual signed above with an "X").*

If applicable, enter "ext." and extension number following phone number above

SIGN ►	SIGN ►
Witness Phone Number or Address	Witness Phone Number or Address

FOR DCF/DDD Office Use ONLY: Include additional information below as needed to help identify the subject (other names used), a specific source, or material to be disclosed.

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 (HIPAA); 45 CFR parts 160 and 164, 42 U.S. Code section 290dd-2, 42 CFR part 2, 38 U.S. Code section 7332, 38 CFR 1.475; 20 U.S. Code section 1232g, (FERPA); 34 CFR parts 99 and 300, and State law.