AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION HIPAA 402P FORM

Purpose:
The **HIPAA 402P Form** is used to obtain an applicant's consent to allow DHH authorization to obtain medical information.

Preparation:
Prepare this form as an original and photocopy it for the applicant (pages 1 & 2). Complete one form per provider, or use the fillable form available on the "BHSF Forms" link on the online application homepage.

Enter the applicant's name and Social Security Number. If the applicant is a child, enter the child's information and document on the Clearance Form. The Request Date is today's date.

I authorize enter name of provider **to release to** Medicaid.

In the, **"Purpose of this authorization"** section, place an "x" in "Creating health information for disclosure to a third party."

In the, "**I authorize the release of the following protected health information,"** section, place an "x" in the box marked "Other". Use standard language: "All records from MO/DAY/YEAR to present. The date will be either 24 months retroactive from the date of the release, or the date of alleged onset of disability (if less than 24 months).

Do not complete the **"Compliance with state or federal laws which requires special permission to release otherwise privileged information, please release the following information"** section.

"This authorization shall expire on the date Medicaid determination is completed **(date or event)."**

Obtain the signature of the individual or their personal representative authorized by law. ***ONLY the signature of the applicant or his or her parent, legally authorized guardian, or curator is acceptable. In NO case may an Application Center complete the signature on the form.***

DO NOT complete any information in the "For DHH Use When Requesting Records" section.

Disposition:
Forward the completed original **HIPAA 402P Form** (pages 1 and 2) to the appropriate Medicaid Office **daily**. A copy of pages 1 and 2 shall be given to the applicant.