

## AUTHORIZATION TO DISCLOSE INFORMATION TO DISABILITY DETERMINATION BUREAU (DDB)

<b>Disclose Records for the Following Person:</b>	
Name: (First, Middle, Last)	
SSN:	Date of Birth:

**INSTRUCTIONS** Read this entire form before signing below. This form lets you voluntarily allow and ask to disclose all your medical and education records, and other information related to your ability to perform tasks. This authorization is good for 12 months from the date you sign below and includes permission to release:

- All records from this facility (including copies of medical records from other facilities if in your chart) regarding your treatment, hospitalization, and/or outpatient care for impairments listed below:
  - 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 or gene-related impairments (including information from genetic test results and/or screenings)
  - Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV) or sexually transmitted disease
- Information about how your impairments affect your ability to complete daily living activities and your ability to work
- Copies of educational tests or evaluations, including Individualized Educational Programs, psychological or speech evaluations, teachers' observations, and any other records that can help evaluate function
- Information created within 12 months after the date you sign this authorization, as well as past information

**This information will be collected from:**

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

**This box is completed by SSA/DDS (as needed).** Additional information to identify the subject (other names used), the specific source, or the material to be disclosed:

This information will be given to the DDB, Division of Health Care Access and Accountability, Department of Health Services, or State of Wisconsin which is authorized to process my case, and which includes contract copy services, and doctors or other professionals consulted during the process. This information is used to determine your eligibility for Medicaid, disability, or Katie Beckett Medicaid applications. **By signing this form you:**

- Authorize the use of a copy (including electronic) or fax of this form for the disclosure of information described above
- Understand that there are some circumstances where this information may be disclosed to other parties (see page 2)
- May write to DDB and other sources to revoke this authorization at any time (see page 2)
- Understand DDB will give you a copy of this form if you ask (you may ask for a copy of materials to be disclosed)
- Have the right to review or request copies of the released material, and that the confidentiality of your records is protected by law
- Have read the entire form and agree to the disclosures above from the sources listed

Individual authorizing disclosure: <b>SIGN ►</b>		If not signed by subject of disclosure, specify authority to sign <input type="checkbox"/> Parent of minor <input type="checkbox"/> POA for Health Care (provide POA papers) <input type="checkbox"/> Legal Guardian (must provide court appointed papers) <input type="checkbox"/> Other personal representative (explain)	
<b>DATE</b>			
<b>WITNESS SIGN ►</b> <i>I know the person signing this form</i>		<b>SECOND WITNESS SIGN ►</b> If needed, second witness sign here (if signed with "X" above)	
Phone or Address		Phone or Address	
<b>Office Use Only:</b> Complete if a telephonic signature is documented by the worker		Individual (First, Middle, Last)	
		Worker ID	Phone Address
Phone (area code)	Street Address		
City		State	Zip Code

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 the Public Health Service Act, Sect. 523 and 527, USC Veterans Benefits, Section 4132, and State of Wisconsin Statutes Sections 19.35 & 19.36, Section 51.30, & DHS 92.03-92.06 Wis. Adm. Code.

## Explanation of Form F-14014

### “Authorization to Disability Determination Bureau (DDB)”

We need your written or telephonic authorization to get the information required to process your application for Medicaid Disability or Katie Beckett Medicaid. Laws and regulations require that sources of personal information have a signed authorization before releasing it to the Disability Determination Bureau (DDB). Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing this form. If you sign such a single authorization, we will make copies of it for each source we contact to get your information. Some individual sources of information may require a new signed authorization after you receive medical treatment. 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.

**You have the right to revoke this authorization at any time**, except to the extent a source of information has already relied on it to take an action. To do so, make a written request to your county social or human services department, the Katie Beckett Program or directly to the Disability Determination Bureau (P.O. Box 7886, Madison, WI 53707-7886). If you do, you should also send a copy of the request to revoke to each of your sources of information. As described below, revocation could result in loss of entitlement.

### IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by the DDB is protected by the Federal Privacy Act of 1974. Once medical information is disclosed to the DDB, it is no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) health information privacy provisions (45 CFR part 164). The DDB retains personal information in strict adherence to the retention schedules established and maintained in conjunction with the National Archives and Records Administration. At the end of a record's useful life cycle, it is destroyed in accordance with the privacy provisions, as specified in 36 CFR part 1228.

The DDB will use the information obtained with this form to determine your eligibility for benefits, and your ability to manage any benefits received. This use usually includes review of the information by DDB staff in processing your case. In some cases, your information may also be reviewed by DDB staff that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

**Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits.** Although the information we obtain with this form is used for the purposes stated above and the information may be disclosed by the DDB without your consent if authorized by Federal laws such as the Privacy Act and the Social Security Act. For example, the DDB may disclose:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist the DDB to establish rights to Social Security benefits and/or Medicaid coverage.
2. To comply with State and local laws requiring the release of information in situations of suspected child or elder abuse.
3. We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, state, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the government. The law allows us to do this even if you do not agree to it.

### If You Need Assistance in Completing This Authorization or Have Questions

If you need assistance in completing this authorization or if you have questions about the authorization, please contact the Medicaid office where you filed your application.