



RELEASE AUTHORIZATION FOR TRANSPORTATION COMPLAINT RESEARCH

Completion of this form authorizes the release of information described in the section below called "Specific Description of Information Authorized for Release." The person whose information is released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. Except for medication /somatic treatment records, a director/designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances.

Name - Person Whose Information Will be Released
Address
City, State, Zip Code
Medicaid Number
Date of Birth

Name & Address - Agency/Organization I Authorize to Release Information To

Name - Information May be Released To
Organization
Address
City, State, Zip Code

Specific Description of Information Authorized for Release
I authorize the release of my information related to my non-emergency transportation issue on:
Date
For complaint description
This includes (provide description)

Purpose or Need for Release of Information (Be Specific)
Authorization for release of information needed to research my complaint for a non-emergency medical transportation issue described above.

- Understandings
• This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility.
• The information that I authorize to be released may be redisclosed by the recipient of the information only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.
• I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release information.
• Unless revoked, this authorization will remain in effect until the expiration time indicated below.

Choose One:
[] Authorization expires as of (Date).
[] Authorization expires month(s) from the date I sign this authorization.
[] Authorization expires after the complaint has been resolved.

As evidenced by my signature, I hereby authorize disclosure of information to the person(s) or agency(s) specified above.

SIGNATURE - Person Whose Information Will be Released
SIGNATURE - Other Person Legally Authorized to Consent to Disclosure
Title or Relationship
Date Signed