DHB- 5028 (02/2020)

NORTH CAROLINA
DIVISION OF HEALTH BENEFITS

---------- COUNTY
DEPARTMENT OF SOCIAL SERVICES

WHOSE *Records to be Disclosed:*

NAME: *First* *Middle* *Last*

SSN: | Birthday mm/dd/yy

ADDRESS:

AUTHORIZATION TO DISCLOSE INFORMATION

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT: ***All my medical records;*** **also 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*, and 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**
   - **Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV) or sexually transmitted diseases**
   - **Gene-related impairments (including genetic test results)**
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM:

- **All medical sources** (hospitals, clinics, 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 SSA/DDS
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY REQUESTING OFFICE (as needed) Additional Information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM: **The State agency authorized to process my case (usually called 'Disability Determination Services'), including contract copy services, and doctors or other professionals consulted during the process; or the county department of Social Services that may review my application.**

PURPOSE: Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability.

EXPIRES WHEN: **This authorization is good for 12 months from the date signed (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 where this information may be redisclosed to other parties
- I may revoke in writing this authorization at any time
- I can get 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 and agree to the disclosures above from the types of sources listed**.

INDIVIDUAL authorizing disclosure:	**IF not signed by subject of disclosure, specify basis for authority to sign (*parent/guardian sign here if two signatures required by State law*):**
Sign>	**[ ]** Parent of minor **[ ]** Guardian **[ ]** Other personal representative (explain)

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP

WITNESS: *I know the person signing this form or am satisfied of this person's identity:*

Sign>	**IF** needed, second witness sign here (e.g., if signed with "X" above): *Sign>*
Phone Number (or Address)	Phone Number (or Address)

Explanation of Form DHB 5028
"Authorization to Disclose Information"

We need your written authorization to help get the information required to process your application for benefits. 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 DHB-5028. 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.

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.

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 revoke, send a written statement to your county Department of Social Services office or the Disability Determination Services. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you. SSA/DDS or DSS can tell you if they identified any sources you didn't tell them about. Information disclosed prior to revocation may be used to decide your claim.

It is Division of Health Benefits (DHB) policy to provide service to people with Limited English Proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 *August 11, 2000) and the individuals with American Disabilities Act. DHB will make every reasonable effort to ensure that the information in the DHB-5028 is provided to you in your native, preferred language, or mode of communication.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by SSA/DDS or DSS is protected by the Privacy Act of 1974. Once medical information is disclosed to SSA/DDS or DSS, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA). SSA/DDS and DSS retain 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 requesting agency is authorized to collect the information by sections 205(a), 223 (d)(5)(A),1614(a)(3)(H)(i), 1631(d)(1) and 1631 (e)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility for benefits. This use usually includes review of the information by the State agency processing your case. In some cases, your information may also be reviewed by personnel 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 almost never used for any purpose other than those stated above, the information may be disclosed by SSA/DDS or DSS without your consent if authorized by Federal laws such as the Privacy Act and the Social Security Act. For example, SSA/DDS and DSS may disclose:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist SSA/DDS to establish rights to benefits.
2. Pursuant to law authorizing the release of information (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs(VA));
3. For statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract with SSA).

Other than the above limited circumstances, SSA/DDS and/or DSS will not redisclose without proper prior written consent information (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

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 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 Disability Determination Office and/or Department of Social Services.