

**HEALTH COVERAGE FOR WORKERS WITH DISABILITIES
(HCWD) MEDICAL INFORMATION RELEASE AUTHORIZATION**

County of _____
Department of Social Services

Dr. _____

Dear Doctor:

Your patient, _____, has authorized us to contact you to obtain information pertinent to their Medicaid eligibility (please see attached signed and dated authorization DHB-5028). Please take a moment to answer the following questions:

1. The patient was previously found to be disabled/blind as that term is defined by Social Security. Does the patient still have the underlying condition or conditions which made them disabled? Yes _____ No _____

2. If the answer is yes, what are those disabling conditions?

3. Is the patient still under treatment for the condition or conditions which made them disabled? Yes _____ No _____

4. If the answer to 3 is yes, is there a strong likelihood that the patient would again be disabled if they were to cease this treatment? Yes _____ No _____

Please print your name

Signature

Today's Date

Please return this document to the Department of Social Services in the envelope provided.