BENEFICIARY REQUEST AND AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, _____, hereby request the North Carolina Division of
(Name of beneficiary or Authorized Representative)
Health Benefits to disclose a Medicaid profile containing claim information for services billed to and paid by Medicaid from the records of the person(s) listed below for this purpose:

Beneficiary's Name	SSN or Medicaid ID Number	From Dates of Service Thru

I understand records will be sent to:

_____

I understand this authorization will expire on this date, event or condition _____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time upon my written authorization. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the beneficiary may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given. I further understand that I may request a copy of this signed authorization.

Individual authorizing disclosure

SIGNATURE _____ DATE: _____

WITNESS SIGNATURE (if required) _____ DATE: _____

If not signed by subject of disclosure, specify basis for authority to sign

☐ Parent of minor ☐ Guardian
☐ Authorized Representative ☐ Other _____

Address Telephone Number