AUTHORIZATION **TO RECEIVE** PROTECTED HEALTH INFORMATION

PORTER STARKE SERVICES
Health • Balance • Hope

Client Name: _____ Date of Birth: _____

Client Address: _____ City/State/Zip: _____

Phone: _____ Client Account Number: _____

The undersigned hereby authorizes Porter-Starke Services to **receive** Medicaid claims data that may include content relating to drug and alcohol use treatment, infectious disease including HIV/AIDS from the agency listed below:

Care Management Technologies, a Relias Company (CMT)

*CMT is a private data company working with the Indiana Division of Mental Health and Addiction and Indiana Medicaid (OMPP) to improve the health of Indiana residents

I fully understand that my medical record contains confidential physical, mental health, substance abuse, and/or HIV/AIDS information compiled in the course of my treatment. The medical records and/or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, as required by law. I understand that records not protected by Federal confidentiality rules (42CFR Part 2) may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that I cannot be required to sign this authorization as a condition for having treatment provided or obtaining payment for the same.

Date, event or condition this authorization expires: _____. If no date, event or condition is specified, this authorization expires 60 days after services have been terminated or when all financial responsibilities have been satisfied. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written or oral revocation request to the Health Information Department.

This information may be disclosed from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client Signature:_____ Date: _____

Relationship to Client: _____ Request Received by: _____

(if signed by responsible party)