COMMONWEALTH of VIRGINIA

*Department of Medical Assistance Services*

CYNTHIA JONES
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
804/786/7933
804/612/0050 (FAX)
800/343/0634 (TDD)

# Authorization for Release of Information

**Section A: Must be completed for all authorizations**

I hereby authorize the use or disclosure of my/our name(s), and photograph as a participant in the Money Follows the Person (MFP) Program by the Department of Medical Assistance Services (DMAS) for publicity purposes. I understand that this authorization is voluntary and will have no effect on my eligibility or status. I also understand that the information released may include my first and last name, image, and details about my circumstances and participation with the MFP program and that the released information will no longer be protected by the federal privacy regulations.

The purpose of the release of my/our name(s) to DMAS is so that DMAS may contact me/us to ask questions about my/our experience with MFP. By agreeing to allow DMAS to contact me/us, I/we are voluntarily participating in the promotion of the MFP program by the Department of Medical Assistance Services (DMAS), Division Long Term Care. My/our participation will be assisting the MFP program with highlighting my experience with the MFP program through promotion of my/my family's personal story and/or images.

Individual's name: _____
Individual's address: _____
Individual's phone numbers: (_____) _____ - _____ (h), (_____) _____ - _____ (w)

Person(s)/Organization(s) receiving the information:
Virginia Department of Medical Assistance Services
600 E. Broad Street, Richmond VA 23219

**Section B: Must be completed for all authorizations**

The individual/family or their representative must read and initial the following statements:

1. I understand that this authorization has no expiration date.
Initials: _____

2. I understand that I may revoke this authorization at any time by notifying the DMAS Division of Long Term Care in writing, but that, if I do, the revocation will not have any affect on any actions the providing organization took before it received the revocation.
Initials: _____

_____
Printed name of person authorizing the Release of Information

_____ _____
Signature of person authorizing the Release of Information or their representative — Date
*(Form MUST be completed before signing)*

Printed name of client's representative (as applicable): _____
Relationship to the client: _____

This form is based on current federal and state law and specifically meets the standard of patient privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR **Part 164**.