

CONSENT AUTHORIZATION FORM FOR RELEASE OF INFORMATION

Health Insurance Premium Payment (HIPP) and HIPP For Kids Program

Purpose: Medicaid eligibility is required for participation in the HIPP/HIPP For Kids Program. Authorization for release of Medicaid eligibility information is required by the HIPP/HIPP For Kids Program when the Medicaid eligible family member does not live in the same household as the policyholder or applicant, who has the health insurance coverage, through their employer's sponsored-group plan. This consent form authorizes the Department of Medical Assistance Services the right to release information about the Medicaid eligible family member(s) eligibility status to the policyholder/applicant. The person who applied for Medicaid eligibility through their local Department of Social Services must authorize this request since it may become necessary for the HIPP/HIPP For Kids Program to communicate information regarding the eligibility status of a family member, to the policyholder, who is not living in the same household.

If the consent form is not signed authorizing release of Medicaid eligibility information, participation in the HIPP/HIPP For Kids Program will be denied.

The consent form must be signed below by the Medicaid eligible family member, if age 18 or older, or by the person who applied for Medicaid eligibility at the local Department of Social Services.

I, _____ (**Print** name of person who applied for Medicaid) authorize the HIPP/HIPP For Kids Program to release Medicaid eligibility information of the eligible family members listed below to _____ (**Print** the Policyholder's name) for the purpose of participation in the HIPP For Kids Program. This authorization will remain in effect as long as there is continuous participation in the HIPP/HIPP For Kids Program. Any break in participation will require a new signed consent form.

Please list the eligible Medicaid family member(s):

_____	_____
_____	_____
_____	_____

Signature of Person Authorizing

Consent: _____

Relationship to Medicaid Family Member: _____

Date: _____ Phone Number _____ (optional)

(Reference: Chapter 2, Page 1, Section 2: HIPP Policy Manual)