COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)
GENERAL CONSENT FOR RELEASE OF INFORMATION

Provider or
Enrollee Name: _____
Date of Birth: _____(month/day/year)

Provider ID or
Medicaid ID # or
Social Security # _____

PERMISSION FOR DMAS TO RELEASE INFORMATION:

I hereby give the Department of Medical Assistance Services permission to release to _____ the following information:
(INDIVIDUAL/ORGANIZATION/PLACE OF BUSINESS)

_____ Medical _____ Psychiatric _____ Financial _____ Medical claims history* _____ Other (Explain below)

(INITIAL LINE TO THE LEFT OF EACH ITEM DESIGNATED)

*Specify time period for Medical claims history which contains services billed to and paid by DMAS

_____

PERMISSION FOR DMAS TO OBTAIN INFORMATION:

I hereby give the Department of Medical Assistance Services permission to obtain from _____ the following information:
(INDIVIDUAL/ORGANIZATION/PLACE OF BUSINESS)

_____ Medical _____ Psychiatric _____ Financial _____ Other (Explain below)

(INITIAL LINE TO THE LEFT OF EACH ITEM DESIGNATED)

_____

This consent is good until _____ (Date)
I understand that I can withdraw this consent at any time by contacting DMAS at the address below.

I understand that DMAS will take reasonable steps in accordance with State and Federal law to safeguard the confidentiality of my medical and personal records. Medicaid is subject to the confidentiality restrictions set forth in 42 CFR 431.300 through 431.307, Virginia Code §32.1-325.4, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Virginia Administrative Code 30-20-90. I also understand that under the Virginia Privacy Act of 1974, I have the right to inspect, correct, or complete this information.

Signed: _____ Date: _____
Enrollee/Provider

If not signing for self (above), state relationship to client, such as: parent of minor, power of attorney, legal guardian or other legally authorized representative. Must provide a copy of court or legal documents.
Relationship: _____

Signed: _____ Date: _____
Witness if signed by mark

This Release form was acknowledged before me this _____ day _____, 20 _____

_____ My commission expires _____
NOTARY PUBLIC

This form contains patient-identifiable information and is intended for review and use by no one except authorized parties. Misuse or disclosure of this information is prohibited by State and Federal laws. If you have obtained this form by mistake, please send it to the address below.

INSTRUCTIONS: The enrollee or provider granting the release must initial the line to the left of each box checked. Return the original to DMAS after making a copy for your files. Mail the original form to:

Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219