

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize The Alabama Medicaid Agency to release any information from my file and the file of my minor child, _____ if applicable, including but not limited to, protected health information under HIPAA and information concerning our eligibility for benefits, medical records, bills, claims for benefits, benefits paid, insurance, and other third party liability coverage, as may be requested by:

a. Any party to the lawsuit entitled:

_____ v. _____

filed in the _____ Court of _____

County, Civil Action No. _____

b. Other:

I certify that my correct recipient identification number is:

(Complete if applicable)

I hereby further certify that I am the parent or legal guardian of:

_____,

and that his/her correct recipient identification number is

_____.

Dated this _____ day of _____, 20 _____.

This authorization expires two years from the date above.

Signature

Print Name/Relationship