

# CHARITIES POOLED TRUST

## Authorization for the Use and Disclosure of Protected Health Information

Federal law states that Entities may not disclose an individual's health information without the individual's permission. By signing this form, you are authorizing All Covered Entities, include state Medicaid agencies and contract representatives to disclose the information you indicate below. If you decide later that you do not want Charities Pooled Trust to be authorized to receive this information any more, you can revoke this authorization at any time in writing. Send Revocation to Charities Pooled Trust, 1217 Ponce de Leon Blvd., Clearwater, FL 33756. Re-disclosure of protected health information is not allowed except in compliance with law or with your written permission. This form must be completed and signed by the Trust Beneficiary or by an individual who has the authority to act on the Trust Beneficiary's behalf (parent of a minor, legal guardian, power of attorney, or personal representative of the estate).

### PLEASE COMPLETE THE FOLLOWING SECTIONS

**1. Personal Information:**

Trust Beneficiary's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**2. I authorize All Covered Entities, including state Medicaid Agencies and contract representatives to disclose my confidential health information listed below to Charities Pooled Trust, its representatives, and legal counsels.**

**3. The purpose for which the disclosure is to be made is to:**

- a. Gain needed information to pay or dispute a Trust Beneficiary's bill for service or product;
- b. Substantiate the State's Medicaid claim against the Trust Beneficiary's Pooled Trust Sub-Account; and
- c. Gain necessary information to determine if a Trust Beneficiary may continue to act as their own Advocate.

**4. The information I would like disclosed to Charities Pooled Trust includes:**

- a. Mental health records, including but not limited to, psychotherapy notes, assessments, treatment plans, attendance, or discharge plans;
- b. Alcohol and drug treatment records, including but not limited to, assessments, treatment plans, attendance, or discharge plans;
- c. All other medical records required to fulfill purposes in section 3; and
- d. The amount that is due Medicaid from the trust account (including a details of items constituting claim)

**5. This authorization shall not expire, except that it may be revoked in writing as stated above.**

I have read and understand the information in this authorization form. I understand that it is possible that information disclosed pursuant to this Authorization may no longer be protected by applicable federal medical privacy law and could be red-disclosed by the person or agency that receives it, however, I do not authorize such secondary disclosure. Therefore, I release All Covered Entities, including state Medicaid agencies, their workforce members, and their contract representatives from all liability arising from the disclosure of my health information pursuant to this agreement. I understand that I may inspect or request copies of any information disclosed by this authorization. I understand that I may revoke this authorization by notifying Charities Pooled Trust in writing, knowing that previously disclosed information would not be subject to my revocation request. I understand that I may refuse to sign this authorization.

Recipient Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

OR

Name of Legal Representative (Print) \_\_\_\_\_ Relationship \_\_\_\_\_

Signature of Legal Representative \* \_\_\_\_\_ Date \_\_\_\_\_

If you are not the individual, but represent the individual, please attach a copy of the legal document that verifies that you are a representative (parent of a minor, legal guardian, trustee, power of attorney, personal representative of the estate).