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REQUEST FOR MARYLAND DIVISION OF REHABILITATION SERVICES AND AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Attach this form to the inquiry requesting Supported Employment authorization in Provider Connect. This form may be faxed to Optum Maryland at 1-855-293-5407 if you are unable to attach to the inquiry.

REQUEST FOR SERVICES FROM DIVISION OF REHABILITATION SERVICES AND NOTIFICATION OF RIGHTS

I am requesting rehabilitation services and give my consent for my DORS application to be submitted with my referral for services. I understand that I will be given a copy of the Opening Doors to Employment, Informed Choice and Client Assistance Program brochures and will have my rights and responsibilities under the DORS program explained during my first meeting with a DORS counselor. Information that I have provided is to the best of my knowledge true, correct and complete. I understand that giving DORS untrue and/or fraudulent information may result in services not being provided or continued. By signing this request, I give permission for DORS to verify my status as a recipient of Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI).

Applicant
Signature/Date: _____

Signature of Parent or
Representative: _____

(if applicant is in high school, under age 18 or has a legal guardian)

INFORMATION GATHERING

The principal purposes served by gathering information requested on the Application, Financial Statement and individualized plan of services are 1) to determine your eligibility for rehabilitation services; 2) to determine what, if any financial participation you may be expected to provide; and 3) to plan your services. Refusal to provide the requested information will result in DORS finding you not eligible for services. You have a right to review, amend or correct the requested information under Code of Maryland Regulation 13A.11.06. The requested information is not available for public inspection, unless you give written permission. The requested information is routinely shared with other governmental agencies when information is needed for you to obtain benefits or services; for audit, evaluation or research purposes connected with the administration of the rehabilitation program as long as confidentiality is safeguarded; and to obtain payment for services which have been provided when covered by third party resources. DORS requests the Social Security Number of applicants for services and uses it only for federal reporting purposes and, as applicable: (1) confirmation of Social Security benefits and presumption of eligibility, and (2) financial transactions.

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION FROM Optum Maryland

Individual/Member Name: _____

Member Identification Number _____

Member Date of Birth ____/____/ ____

I, the undersigned, authorize **Optum Maryland** to release all my individually identifiable health information in their possession to the Maryland **Division of Rehabilitation Services (DORS)** for the purposes of initiating and obtaining the services provided by DORS and to coordinate care. I expressly request that Optum Maryland release:

- all mental health related service authorization correspondence
- all mental health related medical necessity determinations, and
- the medical/clinical information collected from other treating providers in order to make such medical necessity determinations
- all Substance Use Disorder Information including Substance Use History Summaries

This authorization permits **Optum Maryland** to disclose individually identifiable health information about me both prior to and subsequent to the date of my signature for period not to exceed one year or until such time I am no longer eligible for or receiving services from DORS. I understand that signing this document is voluntary and that the authorization to release my information may be revoked at any time.

I understand the information to be released or disclosed may include information, if any, relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. This release permits re-disclosure of this type of information and I explicitly authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restriction of which have been specifically considered and expressly waived.

I Understand and Agree to the following: (45 CFR § 164.508(c)(2)(i-iii))

- I understand that my records are protected under the Maryland Confidentiality of Medical Records Act and Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I have the right to review the information that is being disclosed;
- I do not have to complete this authorization and my refusal will not affect my benefits unless this authorization is necessary to determine my benefits;
  I am refusing to sign: ☐ YES Initials: _____
- The information disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws except to the extent where the information is protected from further redisclosure under federal alcohol and substance abuse law;
- I have a right to revoke this authorization at any time by sending written notice to Optum Maryland. Revoking this authorization will not have any effect on actions that Optum Maryland took in reliance on the authorization prior to receiving notification. For your convenience, a "Revocation of Authorization" Form may be obtained from Optum Maryland **at 1-800-888-1965, TTY 711**

- Optum Maryland will not receive compensation from a third party for using or disclosing this information, and
- I have the right to a copy of this form after I sign it.
  I would like a copy of this form: ☐ YES Initials: ____

Signature of the Individual or the Individual's Legally Authorized Representative**++ Date
(45 CFR § 164.508(c)(1)(vi))

Print Name:

Relationship to the Individual/Member: (45 CFR § 164.508(c)(1)(iv))

☐ Self ☐ Legally Authorized Representative**

☐ Parent of Minor Child (*Power of Attorney, Legal Guardian, Executor or Administrator*)

***If you are signing as a Legally Authorized Representative attach a copy of the appropriate legal document(s) granting you the authority to do so. You do not have to attach copies of documents if you already have those documents on file with Optum Maryland. My legal documents granting authority to act on the individual's behalf are already on file with Optum Maryland*: ☐ YES Initials: _____

++A minor must always sign the authorization form in order to release alcohol and substance abuse information.

The following notice will accompany all substance abuse related hard copy documents released under this authorization:

NOTICE PROHIBITING ANY FURTHER REDISCLOSURE OF ALCOHOL OR DRUG TREATMENT INFORMATION

Prohibition on Redisclosure of Confidential Information

This notice accompanies a disclosure of information concerning a member in alcohol/drug treatment, made to you with the consent of such member. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR) Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of health information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.