

MAP ID: _____

HOUSEHOLD ID: _____

Authorization for the Use & Disclosure of Applicant's Enrollment and/or Application Information

Read this entire form before signing. Complete all the sections that apply to your decisions relating to the disclosure of applicant's enrollment and/or application information.

Name of individual and/or applicant (Last, First, and Middle):

Other name(s) used: _____

Date of birth (MM/DD/YYYY): _____

Address (Street/City/State/Zip Code): _____

Phone: _____ Cell phone: _____

I authorize the following to disclose the individual's protected health information, including enrollment and/or application information ("enrollment information"):

Central Health
1111 E. Cesar Chavez St., Austin, TX 78702
Phone: 512.978.8130, option 1 Fax: 512.776.0457

Who can receive and use the enrollment information?

Individual/Organization name: _____

Address (Street / City / State / Zip Code): _____

Phone: _____ Cell phone: _____

You must complete the form on the back. →



Reason for disclosure

The reason for disclosure is to aid third parties seeking to help potential, current, or former enrollees of Central Health coverage programs in the enrollment process.

Information that can be disclosed

Status of the individual’s enrollment application, including what documents are needed to complete the application process; name of the enrollment program, including coverage effective and end dates; and request and/or pick up an enrollment card.

Effective time period

This authorization will be valid for 12 months from the date the application is submitted, the application is denied (if applicable), or the coverage ends—whichever is later. This authorization will no longer be valid upon the death of the individual or withdrawal of permission.

Right to revoke

I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under “**who can receive and use the enrollment information.**” I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Signature authorization

I have read this form and agree to the uses and disclosures of the information as described. I understand that individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Individual or individual’s legally authorized representative signature:

_____ Date: _____

Printed name of legally authorized representative (if applicable):

If representative, specify relationship to the individual:

- Parent of minor Guardian Other: _____