

**Ohio Department of Medicaid**  
**Authorization for Certificate of Group Health Plan Coverage**

I request the \_\_\_\_\_ County Department of Job and Family Services (CDJFS) to release information regarding my Medicaid or other medical assistance program case to \_\_\_\_\_

I understand that this information is being provided in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The information will be provided to my employer and/or my group health plan so that prior creditable health coverage can be verified. This information may reduce the extent to which any preexisting condition exclusions may be applied to myself or my dependents.

All information and records concerning a recipient of Medicaid or other medical assistance programs are confidential. No information is to be released to anyone except as outlined in rule 5101:1-37-01.1 of the Ohio Administrative Code.

By signing below, I understand that:

- I permit the Ohio Department of Medicaid to provide information that will assist in verifying any creditable health coverage I received while on Medicaid or other medical assistance programs.
- This authorization shall expire on \_\_\_\_\_ or until revoked by me in writing, whichever comes first.
- I have the right to revoke or cancel this authorization at any time by providing notice in writing to: Ohio Department of Medicaid, Attn: Health Information Privacy Official, P.O. Box 182709, Columbus, Ohio 43218-2709.
- The information is released to persons, agencies or representatives of agencies for purposes directly concerned with the administration of Medicaid or other medical assistance programs. Such purposes include establishing eligibility, determining amount of assistance, and providing Medicaid-covered services for applicants and recipients.
- The information can only be released to persons, agencies or representatives of agencies who are subject to standards of confidentiality and safeguarding information which are substantially comparable to those subscribed to by the Ohio Department of Medicaid found in Ohio Revised Code Section 5101.27.
- Any information used or disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it may no longer be protected by federal or state law.
- Completion of this form is voluntary, but necessary to provide information required by HIPAA of 1996.

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Signature of Individual or Authorized Representative

Print name of individual

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Representative's legal authority to individual

Print name of Authorized Representative

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Date

