Ohio Department of Medicaid

Designation of Authorized Representative

Section 1 *(Please Print)*

Name of Applicant/Recipient	Medicaid Billing Number or SSN	County	
Street Address *(include Apt #)*	City	State	Zip

I hereby authorize the following person or entity to act as my representative.

This authority lasts until *(specify a date or event)*, or until it is revoked by me in writing.

Name of Representative	Title	Company
	Patient Advocate	Cognizant RCM obo MetroHealth

Home Phone	Work Phone	Email Address
	800-551-0158	medicaidcorrespondence@metrohealth.org

Mailing Address	City	State	Zip
2816 E 116th St	Cleveland	OH	44120

I authorize my representative to do the following on my behalf:

☑ Act on my behalf in all matters with the agency ["agency" includes the County Department of Job and Family Services (CDJFS), the Ohio Department of Medicaid (ODM), and ODM's contracted designees].

OR only the specific actions selected below:

☐ Assist with my application/renewal for benefits
☐ Represent me at a state hearing
☐ Provide verifications to the CDJFS on my behalf
☐ Receive and respond to copies of all correspondence
☐ Discuss and receive information regarding my financial and medical information including protected health information (PHI)*
☐ Other *(please specify)*

***NOTE** *You must complete Section 2 of this form if this authorization is intended to allow the use or disclosure of PHI.*

While this authorization is in effect, all notices sent by the CDJFS and/or ODM will also be sent to your authorized representative.

Signatures. This form has no effect unless signed by both the person granting authority and by the authorized representative. By signing below, the authorized representative agrees to maintain the confidentiality of any information regarding the applicant/recipient provided by the agency. If the authorized representative is a provider, staff member or volunteer of an organization, then the authorized representative also agrees to adhere to the regulations cited in 42 C.F.R. 435.923(e).

Signature of Person Granting Authority *(Applicant/Recipient or Parent/Guardian)*	Date

Signature of Authorized Representative	Title *(if employee of an organization)*	Date

Section 2

Authorization for the Use and Disclosure of Protected Health Information

Name of Applicant/Recipient	Case Number/Medicaid ID		Date of Birth
Address	**City**	**State**	**Zip Code**

The County Department of Job and Family Services (CDJFS), the Ohio Department of Medicaid (ODM) and ODM's contracted designees *(including Medicaid managed care plans)* are authorized to disclose my protected health information (PHI) to my authorized representative designated in Section 1 of this form.

I hereby authorize the use or disclosure of my protected health information (PHI) as described below.
I understand PHI can include the following types of information, and authorize its disclosure: medical records; substance abuse care; vision care; reproductive care; mental health; communicable disease; pharmacy; HIV/AIDS; dental records; and psychiatric care.

This protected health information may be disclosed:

ALL

The information is being released for the following purpose(s)

Terms and Conditions

By signing below, I hereby authorize the disclosure of my PHI by the agency. I understand that:

- This authorization expires on the following date or event , or upon revocation by me in writing, whichever occurs first.
- I may revoke this authorization at any time. If I revoke this authorization, the revocation is not effective for the use or for the disclosure of my information that has already occurred.
- Any information used or disclosed pursuant to this authorization could be re-disclosed by the person or entity receiving the information, and will likely no longer be protected by federal privacy regulations.
- This authorization is voluntary and that I may refuse to sign it. The provision of treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned on the signing of this authorization, unless the authorization is necessary for determining eligibility for the program or enrollment in the program.
- In the event my records contain psychotherapy notes, a separate authorization may be required for the release of any psychotherapy notes.
- This authorization permits the use and/or disclosure of information related to HIV testing or the treatment of AIDS or AIDS related conditions, drug or alcohol abuse, psychiatric conditions (excluding psychotherapy notes) unless specifically excluded above.

By signing below, I confirm that I have read and understand the contents of this authorization, and confirm that the contents are consistent with my direction to the entity releasing my information.

Signature of Applicant/Recipient	**Date**

If this form is signed by someone other than the Applicant/Recipient, please describe the authority to act on the individual's behalf (*such as Power of Attorney or Legal Guardian*). If not already on record with the agency, please provide legal documentation showing this authority.