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AUTHORIZATION FOR RELEASE

Purpose of disclosure: for the purpose of verification of the undersigned's compliance with the Medicaid Consumer Directed Services program.

PATIENT NAME: _____
LAST First MI

DATE OF BIRTH:_____ SSN:_____

I hereby authorize the information listed in the marked box below to be submitted to Disabled Citizens Alliance (DCAI). Please return the information to DCAI Data entry Department via fax to 573-244-5880.

__X___ Hospitalization/Institution admission and discharge dates.

Acknowledgements:

__X___I understand this authorization will be effective from date of signature and does not have an expiration date.

__X____I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent to the records have already been released.

__X___I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

__X___I understand that a copy of this authorization shall have the same effect as the original.

Patient Signature Date