# State of Alaska

**Department of Health and Social Services**
**3601 C Street, Suite 878 • Anchorage, Alaska**
**99503 (907) 269-3600 • 1-800-770-3930**

## AUTHORIZATION FOR RELEASE OF INFORMATION

Name________________________________________________________________

Medicaid #___________________________Date of birth ___________________________

Person/organization to receive information: *DHSS Section 811 Housing Committee & Sponsoring Agencies*
(list all Sponsoring Agencies): ______________________________________________

Person/organization to release information: *DHSS Section 811 Housing Committee & Sponsoring Agencies*
(list all Sponsoring Agencies): ______________________________________________

Description of information to be released: *Information related to the Section 811 Project-Based Rental Assistance (PRA) program participant, including behavioral health information, as needed for the coordination of care within the Section 811 PRA program.*

The purpose of this authorization is to obtain health care records and financial information needed to determine eligibility to receive or continue to receive services and other benefits through programs managed by the State.

*I authorize the use and disclosure of health care and/or other information described above. I understand that*

- *the* Notice of Use of Private Health Care Information *describes my rights and how my information will be used*
- *my authorization is voluntary, but a refusal to sign this authorization may affect my enrollment or eligibility, for benefits*
- *because my records may contain sensitive information, the individuals and organizations named are limited to requesting and releasing the minimum amount of information necessary*
- *my information may be released to others who must continue to keep this information confidential to the extent required by federal and state law*
- *I may specify the length of time for my authorization will be in effect*
- *my authorization may be revoked at any time in writing on a form that states it is a revocation of my authorization, but the revocation will have no effect on actions that happened before it was received*
- *I may request a copy of this signed authorization*

This authorization will expire upon participant's termination with the Section 811 Project-Based Rental Assistance (PRA) Housing Program.

| ______________________________________ | ______________________________ |
|---|---|
| Signature of named individual or legal representative<br>(or witness, if signature is by mark) | Date |
| ______________________________________ | ______________________________ |
| Printed name of legal representative or witness | Description of representative's authority |

**A photocopy of this authorization is as valid as the original**

**For SDS use only**

Enter date the revocation of authorization was received: ______________________________