# The MOM Care Program
# Appeal and Permission to Disclose Health Information Form

Patient Full Name: _____

Date of Birth: ____/____/_____ Medicaid Number: _____

Current Mailing Address: _____

Item of service you wish to appeal: ◯ Claims/payment denial ◯ Benefit dispute ◯ Choice of different physician

◯ Other: _____

I do not agree with the determination decision because:

_____

_____

I wish to authorize the disclosure of information to the: The MOM Care Program (251)415-8585 located at 1714 Center Street Mobile, Alabama 36604

Information to be disclosed include, but not limited to, Medicaid Records, Care Coordination records, and billing information.

The reason for this disclosure of my Protected Health Information is an appeal against a decision made under the complaint and grievance procedure.

The expiration for this authorization is: ___/___/____ **OR** when a particular event takes place (list event)
*mm dd yy*

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***I understand that if I do not state an expiration date or event that is authorization will expire one year from the date of my signature.***

By signing this form, I give my permission to disclose or release the information stated above from my file on this form for the purpose(s) listed above. I understand that any additional disclosures will require that I complete a new permission form.

I understand that any documents, or records released could potentially be re-disclosed by the above person or class of persons. I also understand that this disclosure of information does not apply to any of my information that is re-disclosed by that party listed above.

I understand that treatment, payment, enrollment or eligibility for benefits does not depend on my signing this form.

I understand that I have a right to revoke (cancel) this authorization at any time. I understand that I must provide you a written request to revoke this authorization. I also understand that any revocation of this authorization shall not affect any disclosures made prior to receipt and process of my written revocations.

Signature: _____ Date: ___/___/____

Witness' Signature: _____ Date: ___/___/____ Time: _____