"We're here to get you there"

Referral for Services

Authorization for Use of Disclosure of Personal Information

1. I authorize Schuylkill Transportation System to disclose individual information as described below from the records of:

Name: _____

Date of Birth: _____ Telephone: _____

Address: _____

Social Security Number: _____

2. Reason for disclosure:

- To qualify for Medical Assistance and/or other benefits available through the PA Dept of Public Welfare.

3. Once application has been made at the Schuylkill County Assistance Office, the date of the application will be disclosed by the Schuylkill County Assistance Office to:

Schuylkill Transportation System Date of D.P.W. Benefits Application: _____

4. I understand that:

a. This authorization may be revoked at any time by writing to the individual/organization identified in section 1 except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.

b. The Department and its health and human services programs will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.

c. Information disclosed pursuant to this authorization may be subject to re-disclosure by the individual/organizations identified and is no longer protected by federal privacy regulations.

d. The Department, its programs, services, employees, officers, and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

e. I may refuse to sign this authorization. I understand that refusal may limit the availability of medical transportation benefits, which includes transportation service for medical transportation from Schuylkill Transportation System.

This authorization applies only to the extent and for the reasons named above. It does not apply to any other agency, organization or reason other than that named above.

_____ _____

Signature of Individual or Personal Representative Date

_____

Relationship to Individual

_____

Signature of Witness (only if individual unable to sign)