HealthSourceRI
YOUR HEALTH. YOUR WAY.

Executive Office of Health and Human Services

Consent to Disclose Protected Information

Purpose of this Form and Your Consent

In order to prepare for your hearing, you may want to have the information that was used in making your eligibility determination. For example, your eligibility determination might be based upon the amount of income you told us you earned last year but that amount did not match what the HealthSource RI found. Another example is where HealthSource RI may have included income from sources you might not have considered such as income you receive from the Social Security Administration.

Under most circumstances HealthSource RI cannot disclose this type of information without certain authorizations.

Your Privacy is Important to Us

At HealthSource RI we are required to protect the privacy of your personal information and we are not permitted to disclose certain kinds of protected information. Despite those protections, some kinds of information may be helpful to you, your authorized representative or your legal representative so that you and/or he or she can better understand your eligibility for certain programs and prepare for your appeal.

If you would like for us to be able to provide the information that was used to determine your eligibility for certain programs, you must follow the steps below.

How to Request Your Protected Information

Please read all of the information provided here and then fill out the release form below.

By completing the form below, you authorize HealthSource RI to release to you, the account holder who applied for health insurance, and your authorized representative (if you have one) certain personally identifiable information which may include information from the Internal Revenue Service and the Social Security Administration.

If more than one taxpayer or beneficiary lives in the account holder's household, please make copies of the release form provided below and have each complete it. This will ensure that all of the information used to make a determination can be provided to you and/or your authorized representative.

You must include the specific information requested on the release form so that we can provide all of the information you are requesting. This includes your name, taxpayer identification number or social security number, address, the type of information you want disclosed, and the reasons for the disclosure.

You must send the completed form to the same location that you filed or intend to file your appeal (for example, the HealthSource RI Call Center, a DHS Field Office or the EOHHS Appeals Office). Please call us at 1-855-849-4774 if you need help filling out this form.

If you agree to these disclosures, your authorization is valid for the amount of time you specify so long as that time is less than or equal to the time of the appeals process. If you do not specify the duration of your consent, it is valid until the appeals process is concluded.

If you have questions about the personal or private information that we collect you can refer to the HealthSource RI Privacy Policy on our website and/or contact us at info@healthsourceri.com or by calling us at 1-855-849-4774. If you have questions about how to make changes or updates to the personal or private information that we collect, please contact us by using this email address or telephone number.

Release to Disclose Protected Information and Authorization of Designated Representative

1. Applicant name		
2. Address		
3. City	4. State	5. ZIP code
6. Social Security Number	7. Telephone number	

Authorization for Disclosure. By signing, I authorize HealthSource RI to disclose information used to make my eligibility determination. I authorize the HealthSource RI to disclose this information to following people:

Primary requestor filing this appeal (name):

_____

Authorized representative:
(name):

_____

The people listed above will be authorized to obtain and use the information for purposes of the appeal hearing. I understand some of the information may come from the Internal Revenue Service and the Social Security Administration and could include:

- My filing status and whether or not a return was filed
- The number for my dependents
- Other information provided by law to determine eligibility for financial assistance to pay for insurance premiums and to reduce out-of-pocket costs when I use health care services
- My income information
- My current monthly Social Security Benefit amount
- The number of coverage quarters I have obtained

Scope. I am requesting information from HealthSource RI to help in the preparation for an appeals hearing. I disagree with an eligibility determination that was made and this information will help resolve the dispute.

8. Duration. Your consent is valid for the amount of time you specify.

1. If you want to authorize disclosure until your appeal is resolved, check here . . . . . ▶ ☐

2. If you want to authorize disclosure for a specific amount of time, write it in the space provided, and check here (no disclosures will occur after the appeal is

resolved) . . . . . ▶ ☐

Until:

Note. If you leave this section blank, your consent will last until the appeals process has concluded.

Authorization. By signing, I understand that the person requesting the appeal, or the named authorized representative will need my information to resolve the appeal. I authorize the requestor or the named authorized representative to receive the information listed above for purposes of resolving the dispute.

9. Signature	10. Date (mm/dd/yyyy)
11. Print Name	12. Relationship (if not the individual)