State of California — Health and Human Services Agency

Department of Health Care Services
Program Services Division — CARE
MS 2601
PO Box 997413
Sacramento, CA 95899-7413

California Access to Recovery Effort

(CARE 3)

Revised June 2013

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I _____ authorize _____
(Client name) (Provider name)

to disclose to the California Department of Health Care Services (DHCS), MAXIMUS (DHCS's voucher services contractor), and the California State Controller's Office (SCO), information regarding my enrollment and services provided in the CARE voucher program.

The purpose of the disclosure authorized herein is to verify my eligibility and participation in the CARE voucher program and to pay the program for services provided.

I understand that my records are protected under the federal confidentiality regulations (42 Code of Federal Regulations, Part 2), and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event, this consent automatically expires six months after I discontinue all CARE services.

I have been provided a copy of this form.

Client Signature: _____ Date: _____

_____ Date: _____
Parent, guardian or authorized representative signature (if required)

Program Name: _____

Program Address:_____

CARE Provider #_____

CARE CALL CENTER | 1-866-350-8773 | OFFICE HOURS: MON - FRI, 8 AM TO 5 PM