STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

June 4, 1986

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATIVE OFFICERS

Letter No.: 86-31

SUBJECT: MC 220A (6/86), AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION - AIDS

Due to changes is state law governing release of medical information, physicians and hospitals are not releasing medical records containing information on AIDS patients without a signed release from the patient specifically stating that information on AIDS testing and treatment is to be released.

As a result, it is necessary to provide a specific release to DED when an individual applies for Medi-Cal as a disabled person and alleges AIDS. Form MC 220A (copy attached) has been prepared and is currently being printed. An emergency supply should be available by June 16. This emergency supply will not have a Spanish translation on the back of the form, however, the translation will be available in time for the normal printing.

It is very important that this new form be in place as soon as possible as DED is unable to determine disability on AIDS patients without adequate medical records. However, under no circumstances are disability packets to be held by the county worker past the ten days allowed in Title 22, CAC, Section 50167. Until the new form is generally available, packets should be submitted using the current form MC 220 and DED will contact the applicant and attempt to obtain an adequate release.

To obtain an emergency supply of the MC 220A, please submit an order form, along with two mailing labels to:

Toni Bailey
Medi-Cal Eligibility Branch
714 P Street, Room 1692
Sacramento, California 95814

As soon as the forms are available, an emergency supply will be shipped to you. You may order a regular supply in 60 days.

Medi-Cal Eligibility Manual Section 4A is being revised to include the new form and will be released under separate cover.

If you have any questions, please contact Toni Bailey at (916) 324-4953.

Sincerely,

Original signed by

Gary Pettigrew, for
Doris Z. Soderberg, Chief
Medi-Cal Eligibility Branch

ATTACHMENT

cc: Medi-Cal Liasons
Medi-Cal Program Consultants

EXPIRATION DATE: August 31, 1986

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION—AIDS

Name of Applicant/Nombre de Solicitante _____

Social Security Number/Número del Seguro Social _____

I.D. Number/Número de Identificación _____
(Hospital, Clinic, VA, or WCAB)
(Hospital, Clínica, Administración de Vetaranos, o WCAB)

I hereby authorize _____

to disclose my medical records or other information for the period beginning _____ and ending
Date/Fecha

_____ to the State agency that will review my application for disability benefits under
Date/Fecha
the Social Security Act.

I further authorize a private photocopy company to photocopy such medical records as are needed as evidence in determining my eligibility for such benefits. I have been informed that the private photocopy company will not release any information about me to any person or agency other than the State agency indicated above.

This consent is subject to revocation at any time, except to the extent that action has been taken in reliance thereon. The duration of this consent shall be no longer than is reasonably necessary to effectuate the purpose for which it is given, i.e., the final determination of my application for disability benefits (including the appeal process) and then will expire without express revocation.

I hereby consent to the release of any and all AIDS testing and treatment, alcohol and/or drug abuse treatment and/or psychiatric records under the same conditions as outlined above. I understand that such information cannot be released without my specific consent, except in special circumstances.

I have read the above and fully understand its contents in its entirety and have asked questions about anything that was not clear to me and am satisfied with the answers I have received. I understand that I have the right to receive a copy of this authorization on request.

_____ _____
Signature of Applicant/Firma del Solicitante Date/Fecha

_____ _____
Signature of Person Acting in Behalf/Firma de la Persona que lo Representa Date/Fecha

_____
Street Address/Dirección

_____ _____
City/Cuidad, ZIP code/Código del Correo Telephone/Teléfono

To Whom It May Concern: Medical reports released to the State's Disability Evaluation program become part of the applicant's file subject to the provisions of the Federal Privacy Act of 1974 which provides that, upon request, an applicant may have access to those records. A condition of access to medical records is that, at the time access is requested, the applicant must designate a representative to receive, review, and discuss them with the applicant. It is recommended, but not required, that the representative be a physician or other health service professional.

COMPLETE ENGLISH SIDE ONLY/COMPLETE ESTE LADO SOLAMENTE

SPANISH ON REVERSE SIDE/TRADUCCIÓN EN ESPAÑOL AL LADO REVERSO