Isiah Leggett
County Executive

DEPARTMENT OF TRANSPORTATION

Al R. Roshdieh
Director

Medicaid Transportation Unit

***** Please sign and return this form. Your application will not be processed without it. *****

*** Authorization for Release of Information ***

I, _____, (print patient's name) hereby authorize and consent to the release of requested information, by Montgomery County Medicaid Transportation Program, for confirmation of any and all scheduled medical appointment(s) with my physicians, medical facilities and/or medical service agencies for which I request transportation by the Montgomery County Medicaid Transportation Program; also, to confirm my attendance at such appointments(s) for which Medicaid transportation services were provided.

Purpose of Release: The purpose of this Release is solely for obtaining confirmation, specifically date and time, of patient's/client's appointments for which Medicaid transportation is requested. In order to provide Medicaid transportation services to eligible recipients, the Program must verify validity of appointments with attending physicians' offices and any other medical facilities or agencies for which the patient/client requested to be transported.

This Release expires on the expiration date of patient's/client's eligibility for Montgomery County Medicaid transportation services.

I, _____, (print patient's name) have read and understood the above statements. I also understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the medical office, medical facility, or agency providing the information, and a copy to the Medicaid Transportation Program.

_____ _____
Signature of Patient Patient's Date of Birth

Address: _____

Telephone #_____ Date: _____

If you had another person complete this form, he/she must provide the following information:

Full Name:_____ Relationship to Patient: _____

Signature of Patient's Representative: _____

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