AUTHORIZATION TO DISCLOSE INFORMATION

_____, _____

Name of applicant or RPY SSN (optional)

I have applied for or currently receive All Kids/FamilyCare medical benefits. I hereby authorize All Kids to release information regarding my family's All Kids/FamilyCare application or eligibility to:

_____

Name of person or organization authorized to receive the information

- All Kids may share information about my family's application or eligibility only for the purposes of helping me to apply for All Kids/FamilyCare or to help me understand eligibility rules or coverage.
- I agree that this authorization will last as long as I am enrolled in All Kids/FamilyCare or until I tell All Kids to revoke the authorization.
- I can revoke this authorization at any time by signing the Revocation at the end of this form and sending it to All Kids.
- All Kids cannot refuse payment or deny enrollment or eligibility for benefits if I do not sign this Authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations.
- All Kids cannot promise that the person or organization that I permit All Kids to share my information with will not share my information with someone else I may not want to have my information.
- I can keep a copy of this Authorization, and can call All Kids at 1-877-805-5312 to get a copy if I do not have one.

A copy or fax of this authorization form shall be as valid as the original.

My date of birth is ___-____-____

My complete address is: _____

_____

_____

Signature: _____ Date: _____

Applicant or RPY

To revoke this authorization, sign and date the revocation below and send it to All Kids at P.O. Box 19122, Springfield, Illinois 62794-9122.

REVOCATION OF AUTHORIZATION

I no longer want All Kids to share my health information with the person indicated above.

Signature: ..... Date: .....