Authorization for Release of Information - (MATP - PA4)

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Medical Assistance
Transportation Program

Last Name:	First Name:		Initial:	Date of Birth:
SSN:	MA Recipient #:		Phone #:	
Street Address:			Apartment #:	
City:	Municipality:	County:	State:	Zip:
Emergency Contact:		Relationship:	Phone #:	

55 Pa. Code § 2070.25 requires providers of medical services to give access to and allow the use and disclosure of information on applicants and clients to: Federal authorities, the Commonwealth, the Department, the County Commissioners or County Executive, and prime contractors or their authorized agents, if the information is necessary to the administration of the Public Assistance Transportation Block Grant. I hereby authorize and request the disclosure to the Medical Assistance Transportation Program any information concerning the age, residence, citizenship, employment, education and training activities, and any additional information, including medical information and treatment plans, pertaining to eligibility for Medical Assistance Transportation and /or specific transportation requests under the MATP. It is understood that the information obtained will be used only for purposes directly related to the Medical Assistance Transportation Program.

Signature of Applicant _____ Date Signed _____

Applicant Name Printed _____

Signature of Designee (person signing on behalf of applicant) _____ Date Signed _____

Designee Name Printed _____

Signature of Witness _____ Date Signed _____ Title _____

Witness Name Printed _____