WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02340 (05/2023)

ROI

RELEASE OF CONFIDENTIAL INFORMATION AUTHORIZATION FOR WISCONSIN MEDICAID, BADGERCARE PLUS, FOODSHARE, FAMILY PLANNING ONLY SERVICES, SENIORCARE, AND CARETAKER SUPPLEMENT

Complete and submit this form to authorize the release of information indicated in Section 2 below. The person whose information is released may have a right to inspect and, upon paying any applicable fees, get a copy of the disclosed information.

SUBMISSION INSTRUCTIONS

If the person whose information will be released lives in **Milwaukee County**, do one of the following:

- Fax the form to 1-888-409-1979.
- Mail the form to:
  MDPU
  6055 N. 64th St.
  Milwaukee, WI 53218

If the person whose information will be released does **not** live in Milwaukee County, do one of the following:

- Fax the form to 1-855-293-1822.
- Mail the form to:
  CDPU
  PO Box 5234
  Janesville, WI 53547

SECTION 1 Personal and Contact Information

Part A: Person Whose Information Will Be Released

Name – Person Whose Information Will Be Released (Last, First, Middle Initial)

Case Number (if known)	Date of Birth

Street Address

City	State	Zip Code

Part B: Person or Organization Information May Be Released To

Name – Person or Organization Information May Be Released To

Street Address

City	State	Zip Code

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Part C: Agency/Consortia Authorized to Release Information

Name – Income Maintenance or Tribal Agency/Consortia Authorized to Release Information

Street Address

City	State	Zip Code

SECTION 2 Information Authorized for Release

Indicate the information authorized for release:

- ☐ Current eligibility status for health and nutrition programs
- ☐ Information used to determine eligibility for health and nutrition programs
- ☐ Other eligibility information – specify:

Indicate the purpose or need for the release of information. Be specific.

Indicate the date the authorization should end. The date must be within 12 months of the date this form is signed. If a date is not provided, the authorization will end 12 months from the date this form is signed.

SECTION 3 Statements of Understanding and Signature

- I am authorizing the release of information to the person or organization indicated in Part B of Section 1.
- This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment, or benefits eligibility.
- The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.
- I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency/consortia I authorized to release information.
- Unless revoked, this authorization will remain in effect until the expiration time indicated in Section 2.

SIGNATURE – Person Whose Information Will Be Released	Date Signed

RESET FORM

USDA Joint Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: SNAP Hotline.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.