RELEASE AUTHORIZATION

This form must be completed and signed by the client and submitted with their RMA application via eRED. This form is valid for one year from the effective RMA date, or for the full duration of RMA coverage.

APPLICANT INFORMATION

APPLICANT FULL LEGAL NAME (FIRST, MIDDLE, LAST):	ALIEN NUMBER:
Francisco SAENZ VALDES	217264710

AUTHORIZED REPRESENTATIVE

I want the below individual or organization to apply for benefits or act on my behalf, called an "Authorized Representative".

(•) Yes ( ) No

NAME OF AUTHORIZED REPRESENTATIVE:	
Bridge Refugees - Chattanooga	
EMAIL:	PHONE NUMBER:
anurag.yadav@dotsquares.com	232-132-1323

RELEASE OF PRIVATE HEALTH INFORMATION

I authorize the below resettlement agency to receive and review my Private Health Information (PHI) and Personal Identifying Information (PII)".This authorization covers USCRI and all applicable Business Associates as defined in the Health Insurance Portablility and Accountability Act of 1996,for actions necessary for medical treatment and claims processing and payment relating to covered individuals

NAME OF LOCAL RESETTLEMENT AGENCY:
Refugee Services of Texas - Austin

INFORMATION TO RELEASE:

☑ **ALL INFORMATION**

Or

☐ Appeal	☐ Financial	☐ Referral
☐ Benefits/Coverage	☐ Medical Records	☐ Treatment
☐ Billing	☐ Doctor/Hospital	☐ Dental/Vision
☐ Claims/Payments	☐ Precertification	☐ Pharmacy

POLICY:

I understand that USCRI is not a HIPAA Covered Entity subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")and the privacy, security and breach notification regulations promulgated thereunder (45 CFR Parts 160 and 164) (the "HIPAA Regulations"), because it is a government-funded program that is exempt from the definition of a "Health Plan" under the HIPAA Regulations. I also understand that even though USCRI is not a HIPAA Covered Entity, it chooses to follow HIPAA Regulations as a best practice. The above client has the right to revoke authorization access at any time and may do so by emailing USCRI at medical.assistance@uscrimail.org.

SIGNATURE

I certify that the information I have provided on the RMA application is true and complete to the best of my knowledge. By signing, I give authorization for the release of information as indicated on this form.

RMA ENROLLEE'S SIGNATURE:	DATE:
AUTHORIZED REPRESENTATIVE'S SIGNATURE:	DATE:

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