Isiah Leggett
County Executive

DEPARTMENT OF TRANSPORTATION

Al R. Roshdieh
Director

Medicaid Transportation Program

NOTICE OF PRIVACY PRACTICES

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

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED.

We may contact your doctor to verify your medical condition for Medicaid transportation purposes only.

Any medical information provided to us concerning your diagnosis, symptoms, treatments, medical and/or doctors' visits or any other details regarding your healthcare, is strictly confidential and will not be disclosed or used for any purpose other than determining your eligibility for the use of Medicaid Transportation services.

The Medicaid Transportation Program requests that you acknowledge receipt of this notice by signing and returning this form to the Medicaid Transportation office.

Patient's Name: _____

Signature: _____

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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