Exhibit B

**Ohio Department of Job and Family Services**

# APPLICANT/RECIPIENT AUTHORIZATION FOR RELEASE OF INFORMATION

| Office Use Only | |
|---|---|
| Applicant/Recipient Name | Case Number |
| | |
| Name of CDJFS Representative/Unique Identifier/Date | |
| Marcie Parker | |

I _____. hereby authorize _____ to disclose
(Name of Individual) (Name of covered entity, such as CDJFS, employer, etc.)

the information listed below to Union County Human Services for the purpose of determining
(Who will receive the information?)

eligibility for cash assistance, medical assistance and/or food stamp benefits; or for the following reason(s): permission to verify information electronically, verbally and in writing if client is eligible for Net Transportation.

**Information to be released:** UCDJFS will verify if the above named client is Medicaid eligible for Net Transportation with the above named Vendor.

**By signing below, I understand that:**

This authorization shall expire on until revoked by client or until revoked by me in writing, whichever comes first.
(Date or completion of "event"- reason the signed authorization is needed)

I have the right to revoke or cancel this authorization at any time by providing notice in writing to the following address: Union County Human Services, PO Box 389, Marysville, OH 43040

The revoking or canceling of this authorization does not affect the use or disclosure of information that occurred prior to the date that authorization was canceled.

Any information used or disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it may no longer be protected by federal or state law.

This authorization is **NOT** for the release or use of protected health information (PHI) – please use the appropriate medical release authorization form.

I am aware of my responsibilities to report completely and fully all facts that bear upon my eligibility for all cash assistance, medical assistance and/or food stamp benefits. I realize if the requested information reveals I have improperly reported my situation, the information may be given to the prosecuting attorney for possible civil action or criminal prosecution.

Completion of this form is voluntary, but necessary to determine eligibility for cash assistance, medical assistance and/or food stamp benefits.

| Signature of Applicant/Recipient or Authorized Representative | Date | Representative's Legal Authority to Applicant/Recipient (Such as parent, guardian, power of attorney, auth rep, etc.) |
|---|---|---|
| | | |

**Please reply in the space below, sign and date.**

_____

_____

_____

_____

**Signature/Title of Person Supplying Information** **Telephone Number** **Date**

JFS 07341 (04/2004)