Liberty Healthcare Corporation
THE FREEDOM TO SUCCEED™
Idaho Independent Assessment Services Program
8850 W. Emerald St. – Suite 164 | Boise, ID 83704 | 208.258.7980 | FAX: 208.258.7985 |
EMAIL: idahoias@libertyhealth.com

Plan Developer Choice Form

Participant Name: _____

I choose the following Plan Developer AND Agency as my Plan Developer/Support Broker/Agency for the upcoming Plan Year:

Plan Developer/Support Broker Name **(REQUIRED):** _____

Service Coordination Agency **(REQUIRED for DD Waiver – Traditional and State Plan; NOT required for DD Waiver – Self-Direct):** _____

Plan Developer/Support Broker's email address: _____

Service Coordination Agency Email address: _____

Plan Developer/Support Broker's phone number: _____

I hereby authorize Liberty Healthcare Corporation to: **(CHECK ALL THAT APPLY)**

____ OBTAIN AND/OR ____ DISCLOSE

____ SCHEDULE WITH AND/OR ____ RESPOND TO ASSESSMENT

My confidential information to/from the above-named Service Coordination Agency or Non-Paid Plan Developer or Independent Support Broker.

The following information **(CHECK ALL THAT APPLY)** will be transmitted:

___ Independent Assessment Results ___ Functional Assessment Results ___ Treatment Plans ___ Physician Medical Documentation ___ Psychiatric and Psychological Documentation

___ Other: (Please Specify)_____

This authorization will expire within 365 of the date this PD Choice Form is signed unless an earlier date is provided in writing.

I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand and certify that I may revoke this authorization at any time by notifying Liberty's HIPAA Privacy Officer in writing at the address noted above. The revocation will only be effective from the date it is received in this office and will not apply retroactively. Information disclosed pursuant to this authorization may be subject to re-disclosure and Liberty assumes no responsibility for the use or misuse by others of my health information used, and/or disclosed under this authorization.

PARTICIPANT/LEGAL GUARDIAN (Print Name): _____Date:_____

SIGNATURE: _____

CO-LEGAL GUARDIAN (Print Name): _____Date:_____

SIGNATURE: _____

THIS FORM MUST BE RETURNED TO LIBERTY HEALTHCARE