CONSUMER CHOICES OPTION

Account Information Authorization

Name of Member:	State ID/Medicaid number of Member:

I am participating in the Consumer Choices Option Program and have chosen to give authority to the following individual(s) to have access to information regarding my account. This may include balance information, payment information and status of budget requests. (Please include name of parents and case workers)

Name of Individual to have access	Relation to Member
Email address	Phone
Name of Individual to have access	Relation to Member
Email address	Phone
Name of Individual to have access	Relation to Member
Email address	Phone
Name of Individual to have access	Relation to Member
Email address	Phone
Name of Individual to have access	Relation to Member
Email address	Phone

A copy of this form must be submitted to the Financial Management Service. This authorization shall be effective as of the date that it is and shall continue until such time as the member or guardian gives written notice that it is being terminated.

_____ _____

Member's Signature Guardian's Signature, if applicable

_____ _____

Date Date