AUTHORIZATION FOR RELEASE OF MEDICAID PROTECTED INFORMATION FROM THE NEW YORK STATE DEPARTMENT OF HEALTH, OFFICE OF MEDICAID MANAGEMENT TO A THIRD PARTY OTHER THAN A MEDICAID ENROLLEE/PATIENT

Enrollee/Client Name: _____ Client Identification Number (CIN): _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider or clearinghouse, the released information may no longer be protected by federal privacy regulations, except that a enrollee/patient may be prohibited from redisclosing substance abuse information under the federal substance abuse confidentiality requirements. State law governs the release of HIV/AIDS information and you may request a list of persons authorized to re-release HIV/AIDS related information. Authorizations for the release of HIV/AIDS data must comply with the requirements of Article 27-F of the Public Health Law. Authorizations for the release of alcohol and substance abuse records must comply with the requirements of 42 C.F.R. part2.

Persons/organizations authorized to receive or use the information:

Name _____

Address _____City _____State_____ Zip_____

Phone Number _____

1. Purpose of the use/disclosure: _____

2. Will the person/program requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No _____

3. I understand that my health care and the payments for my health care will not be affected if I do not sign this form except in some situations when information is needed for payment, enrollment, etc.

4. I understand, with few exceptions, that I may see and copy the information described on this form if I ask for it, and that I may get a copy of this form after I sign it.

5. I may revoke this authorization at any time by notifying the Department of Health in writing, but if I do it will not have any effect on any actions they took before they received the revocation.
   This authorization will expire in 30 days of receipt in this office.

_____
Signature of Medicaid Enrollee Date _____

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State of New York }
} ss..
County of New York }

On this _____day of _____, 20__, before me personally came and appeared _____, to me known to be the individual described in, and who executed this Medicaid records authorization in my presence and duly acknowledged to me that (s)he executed the same.

Please return to
Office Medicaid Management
NYS Department of Health
99 Washington Avenue
Suite 720
Albany, NY 12210

_____
Notary Public

authorization