

**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): \_\_\_\_\_

**By signing this form, I understand that I am allowing the New York State Department of Health to use or disclose all of my payment information as indicated below. This may include data on certain conditions such as HIV/AIDS, Mental Health and Alcohol and Substance Abuse.**

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 the health plan's eligibility or enrollment determinations relating to the individual.

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 at the address below, but, if I do, it will not have any effect on actions that the Department took before they received the revocation. If not previously revoked, this authorization will expire upon completion of this request.

6. 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, and therefore the recipient of the confidential data may redisclose the confidential data.

\_\_\_\_\_  
Signature of Medicaid Enrollee Date

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 Notary Public  
Suite 720 Authorization  
Albany, NY 12210