

**NEW YORK STATE DEPARTMENT OF HEALTH  
OFFICE OF HEALTH INSURANCE PROGRAMS  
AUTHORIZATION TO RELEASE PROTECTED MEDICAID MEMBER INFORMATION TO A THIRD PARTY**

Medicaid Member Name (required): \_\_\_\_\_

Date of Birth (required): \_\_\_\_/\_\_\_\_/\_\_\_\_

**At least one of the following identification numbers is required, preferably both.**

Client Identification Number (CIN): \_\_\_\_\_ Social Security Number (SSN): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**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.**

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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 or one year from the date this form is signed, whichever comes first.

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 re-disclose the confidential data.

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\_\_\_\_\_

Signature of Medicaid Member or Agent

\_\_\_\_\_

Date

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If not member, name of person signing for member

Authority to sign on behalf of member

Please return to:

Records Custodian  
NYSDOH, Medicaid Information Services Center of New York  
800 North Pearl Street, Room 322  
Albany, New York 12204

## **GUIDELINES FOR AUTHORIZING THE RELEASE OF MEDICAID RECORDS**

1. The New York State Department of Health's website contains information on how to obtain Medicaid payment records and the Authorization for Release of Medicaid Protected Information.
  - [www.nyhealth.gov](http://www.nyhealth.gov) - click on **Medicaid**, click on **Program Information**, click on **Obtaining Confidential Medicaid Payment Information**.
  - [www.nyhealth.gov](http://www.nyhealth.gov) - click on **Forms**, click on **M**, click on **Obtaining Medicaid Payment Records**.
2. The request must consist of both a letter of request **AND** a valid authorization along with any other supporting documentation.
3. The letter requesting Medicaid payment records **MUST** include the member's **name AND date of birth, dates of service** the report should cover, **AND at least one of the following**:
  - **Medicaid Member Client Identification Number (CIN)**
  - **Social Security Number**.
4. Authorizations **MUST** be originals. **PHOTOCOPIES AND FAXES ARE UNACCEPTABLE**.
5. Authorizations are valid for **ONE YEAR ONLY** from date of signing, even if the signer designates a later expiration date or no expiration.
6. If a person other than the Medicaid member signs the authorization, legal documentation authorizing the signer to act on behalf of the member **MUST** be included.
7. Authorizations **MUST** state to whom the record is to be sent.
8. Authorizations **CANNOT** contain whiteout, substitutions, or deletions.
  - **SPECIAL NOTE:** If using OCA Form 960 you **MUST** fill out and initial all authorizations, including those for Alcohol/Drug Treatment, Mental Health Treatment, and HIV-Related Information. **We have no way to exclude this information**. If you do not approve their inclusion, we cannot release a report to you.

**THE OFFICE OF HEALTH INSURANCE PROGRAMS WILL RETURN ANY AUTHORIZATION THAT DOES NOT MEET THE ABOVE GUIDELINES.**