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.

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.

_____ _____

Signature of Medicaid Member or Agent Date

_____ _____

If not member, name of person signing for member Authority to sign on behalf of member

Please return to:

Medicaid Data Warehouse - CDRs
NYSDOH – MISCNY
ESP P1-11 S Dock J
Albany NY 12237