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): ____ – ____ – _____

Persons/organizations authorized to receive or use the information:

Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone Number: (____) ____ – _____

Dates Authorized: ☐ All OR From: ____ / ____ / ____ To: ____ / ____ / ____ OR ☐ To Present

Purpose of the use/disclosure: _____

1. 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.
2. 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.
3. 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.
4. 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.

By signing this form, I understand that I am allowing the New York State Department of Health to use or disclose all of the payment information for the Medicaid Member as indicated above, including data on certain conditions such as HIV/AIDS, Mental Health and Alcohol and Substance Abuse. I specifically authorize release of such information to the person(s) indicated above as the recipient.

_____ _____
Signature of Medicaid Member or Agent Date

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

_____ _____
Witness Signature Witness Name

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