NEW YORK STATE DEPARTMENT OF HEALTH
State Disability Review Unit

Authorization to Release
Protected Medicaid Applicant/Recipient Information to a Third Party

Section I

Medicaid Applicant/Recipient Name:	Date of Birth:	Social Security Number (Last four digits):
Address:	Client ID Number(CIN):	Disability ID Number(DIN):

By signing this form, I understand that I am allowing the New York State Department of Health to disclose my consultative medical report to the person(s), health provider or entity listed in Section II. This may include information on certain conditions such as HIV/AIDS, Mental Health and Alcohol and Substance Abuse.

Section II

1. Name of the person(s), health provider or entity authorized to receive or use this information:

2. Address:

3. Phone Number:
( )

1. Purpose for the release of information: To provide the individual's designated treating physician with a copy of a consultative medical report, as requested by the applicant/recipient.

2. I understand 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.

I authorize the New York State Department of Health State Disability Review Unit to release health information of the person named in Section I to the person(s), health provider or entity authorized in Section II.

SIGNATURE OF THE APPLICANT/RECIPIENT OR REPRESENTATIVE AUTHORIZED BY LAW

DATE

Please return to: **State Disability Review Unit OCP-826**
State of New York
Department of Health
Albany, NY 12237