NEW YORK STATE DEPARTMENT OF HEALTH
State Disability Review Unit

Authorization for Release of Health Information Pursuant to HIPAA

Patient Name:	Date of Birth:	Social Security Number (Last four digits):
Doe, John	01/01/1900	123-45-6789
Address:	**Client ID Number(CIN):**	**Disability ID Number(DIN):**
123 Main Street, Anytown, NY 12345		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to Alcohol and Drug Abuse, Mental Health Treatment, except psychotherapy notes, and Confidential HIV Related Information, unless I check the appropriate box(es) in section 9(c). Otherwise, in the event the health information described below, in section 9(a), includes any of these types of information, and I initial the line on the box in section 9(b), I specifically authorize release of such information to the person(s) or entity indicated in Section 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (888) 392-3644 or TDD/TTY (718) 741-8300
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below in Section 7. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. If not previously revoked, this authorization will expire upon completion of this determination/review or one year from the date this form is signed, whichever comes first.
4. I understand that signing this authorization is voluntary. I understand that the State Disability Review Unit requires the completion of this form in order to gather health information necessary for a disability determination. I understand that without this authorization, my eligibility for Medicaid benefits may be affected.
5. Information disclosed under this authorization might be re-disclosed by the Department of Health (except as noted under item 2), and this re-disclosure may no longer be protected by federal or state law.
6. This authorization does not authorize you to discuss my health information or medical care with anyone other than the government agency specified in Section 9(b).

7. Name and address of the health provider or entity authorized to release this information:

Dr Seuss - 456 Main Street, Anytown, NY 12345

8. Name and address of person(s) or agency to whom this information is to be sent:

Organization Submitting Trust to Medicaid - 789 Main Street, Anytown, NY 12345

9(a). Specific information to be released:

☐ Medical records from _____ (date) to _____ (date).

☐ Entire Medical Record, including patient histories, office notes(except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

9(b). Authorization to discuss Health Information:

By initialing here JD I authorize Dr. Seuss
(NAME OF INDIVIDUAL/HEALTH CARE PROVIDER)

to discuss my health information with the **State Disability Review Unit**.

9(c). I do not consent to the disclosure of (Check all boxes that apply): ☐ Alcohol/Drug Treatment ☐ Mental Health Information ☐ HIV-Related Information

10. Reason for release of information: ☐ At request of individual ■ Other: At request of HRA

11. Purpose of the Use/Disclosure: **Disability Determination and Review**

12. If not the patient, name of the person signing this form (print): At request of HRA

13. Type of authority to sign on behalf of the patient: At request of HRA

All sections on this form have been completed and my questions about this form have been answered.
I authorize the facility/person noted on this page to release health information of the person named on this page to the New York State Department of Health State Disability Review Unit.

SIGNATURE OF THE PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW

DATE

Instructions for Completing the Authorization for Release of Health Information Pursuant to HIPAA

The "Authorization for Release of Health Information and Confidential HIV-Related Information" form gives permission to your healthcare providers (hospitals, doctors, therapists, etc.) to send in copies of your health records to the State Disability Review Team. These health records will help the Disability Review Team determine if you are disabled. You will need to fill out and send one of these forms to every one of your healthcare providers that needs to send in your medical records.

The box at the top of the form will be filled in. If the information is incorrect, please put a line through what is incorrect and write in the correct information.

Read the information in items 1-6 found under the top box, before filling in the rest of the form. These paragraphs give you information on the type of health information that you can choose to be sent by your healthcare providers, your rights to authorize the release of your health records and how to stop the authorization, and who is allowed to see your health information.

7) Put the name and address of the healthcare provider who is to send your health records to the State Disability Review Team. **Fill out one form for each of your healthcare providers.**

8) Informs the healthcare provider to whom to send the health records. This box will be already filled in with the State Disability Review Team's information.

9a) • If you want the healthcare provider to send your medical records for a certain period of time, put a check in the first box and enter the dates for the time period. To make a disability determination, at least 12 months of health records are needed for the time period in which the disability is being determined.

• If you want the healthcare provider to send your entire medical record, put a check in the second box.

• If you want the healthcare provider to send in any other information, put a check in the third box (Other) and write the information that the healthcare provider is to send.

9b) If you want to allow your healthcare provider to speak with someone on the State Disability Review Team, put your initials and the name of your healthcare provider on the lines provided.

9c) Under 9(c), check the boxes for the type of medical information that your healthcare provider is not permitted to send.

10) Check the box if the individual requested the release of information, or check Other and state the reason for the request.

11) The purpose of this request is for a disability determination and review.

12) If you are not the patient filling out the form to request medical records, print your name.

13) If you are the legal representative of the patient, put the relationship you have to the patient. For example, if the patient is a child and you are the parent, put parent. If you are the legal guardian of the patient, put legal guardian.

If you want your healthcare provider to send your medical records, this form must be signed and dated by the patient or the patient's legal representative.