AUTHORIZATION FOR DISCLOSURE OF INDIVIDUAL HEALTH INFORMATION
(Individual/Business/Consumer Representative

Human Resources Administration
Department of Social Services

MAP-751D (E-S).....Rev. 08/18/08

PLEASE PRINT ALL INFORMATION

LOG #

SECTION A: COMPLETE THIS SECTION TO AUTHORIZE DISCLOSURE OF YOUR MEDICAID INFORMATION

Name: _____ SS#: _____ CIN: _____

Address:(where you want information sent) _____

The NYC Medical Assistance Program is the provider of any information that is disclosed as a result of this request.

I hereby authorize the use or disclosure of my individually identifiable health information as described below.
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, except that other federal and state laws may prohibit the recipient from redisclosing information that may concern alcohol or substance abuse treatment or HIV/AIDS. In accordance with state law you may request a list of persons authorized to re-release HIV/AIDS related information.

1. I understand that I will get a copy of this form when required by law.

2. I may revoke this authorization at any time by notifying the Medical Assistance Program in writing. I also understand this revocation will not take effect until it is received.

3. The Medical Assistance Program have not required me to sign this Authorization as a condition of receiving Medicaid benefits.

YOU MUST ANSWER THE QUESTIONS BELOW AND CHECK ALL RELEVANT BOXES:

4. a) ☐ I authorize (print-person/organization) _____ to act on my behalf and represent me with Medicaid. This Authorization will expire on _____.
THIS AUTHORIZATION IS SPECIFICALLY LIMITED TO INQUIRING AND RECEIVING MY ENROLLMENT INFORMATION, RESOLVING ELIGIBILITY ISSUES AND OTHER BENEFIT MATTERS THAT MAY ARISE.

b) ☐ I authorize (print-person/organization) _____ to receive a copy of my Medicaid records.

c) Describe in detail the records to be disclosed **and be specific if you are limiting your request**. _____

_____

_____ for the period of _____ until _____.

I consent to the release of my confidential HIV/AIDS information, Mental Health information and Alcohol and Substance abuse information **unless a box is checked.**

DO NOT DISCLOSE INFORMATION ON: ☐ **HIV/AIDS** ☐ **Mental Health** ☐ **Drug and Alcohol**

5. Have you received Medicaid services from any of the following?

☐ Home Attendant/Housekeeping Programs ☐ Assisted Living Program ☐ Nursing Home Program
☐ Long Term Home Health Care Program ☐ Managed Long Term Care Program ☐ Adult Protective Services
☐ Food Stamp Program

6. While receiving Medicaid have you ever been: ☐ Disabled ☐ Restricted to a specific Doctor or Pharmacy?

7. Have you received Medicaid Transportation services (ambulance, ambulette etc.)? ☐ Yes ☐ No

8. Have you asked for a Medicaid Managed Care Exemption? ☐ Yes ☐ No

Signature: _____ Phone: _____ Date: _____

Acknowledged Medicaid representatives must submit this form through their normal Medicaid channels. LEGAL Medicaid business representatives must mail this form to MAP HIPAA Official, 330 West 34th Street New York , NY. 10001.

OTHER PERSONAL REPRESENTATIVES MUST TAKE THIS FORM AND PHOTO ID TO A MEDICAID OFFICE

Section B: TO BE COMPLETED BY WORKER ACCEPTING REQUEST OR AUTHORIZATION

☐ I have verified the identification provided by client's representative.
☐ Authorized Representative accepted by MAP program area.

Name (Print) _____ Phone: _____ Date Received: _____

RESPONSE TO YOUR AUTHORIZATION REQUEST

SECTION C: TO BE COMPLETED BY THE MEDICAL ASSISTANCE PROGRAM HIPAA OFFICIAL

The request made by the Medicaid recipient listed in the top of Section A above has been:

☐ **APPROVED:** Copy of all documents attached.
☐ **PARTIALLY APPROVED:** Copy of documents attached except those determined by a licensed health care professional, in the exercise of sound professional judgement, to be excludable by law. **IF YOU WISH TO APPEAL THIS DECISION COMPLETE AND SUBMIT THE ATTACHED FORM.**
☐ **DENIED and NOT APPEALABLE because:**

☐ The Medical Assistance Program has no information about you in the designated Medicaid records set.
☐ The authorization is defective.
☐ Other _____

Signature of HIPAA Official: _____ Date: _____

You may file a complaint with: The Office for Civil Rights, Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza, Suite 3312, New York, NY 10228; Telephone 212 264-3313 or 1-800-368-1019; Fax 212 264-3039, or TDD 212-264-2335. You may also file a complaint with NYS Medicaid Help Line Office, 518-486-9057 or 1-800-541-2831. TTY users should call 1-800-662-1220. You will not be penalized for filing a complaint.