

**“How To” Guide for the New York Independent Assessor (NYIA)  
Information Sharing Consent Form for Authorized Representatives**  
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This fact sheet is posted at <http://www.wnyc.com/health/download/817/>  
Last Updated: July 27, 2022 - Check there for updates

The New York Independent Assessor (NYIA) released a consent form for you to authorize release of health information to NYIA. The consent form allows NYIA to contact your doctors and other medical providers as needed for them to assess your eligibility to enroll in a Managed Long Term Care (MLTC) plan, or for you to obtain Medicaid personal care or Consumer-Directed Personal Assistance (CDPAP) services from your local Medicaid office or Medicaid health plan. You can also designate an authorized representative who may act on your behalf when interacting with NYIA.

To find the form, go to <https://nyia.com/en/consent> . PDF copy is also attached to this Guide.

This guide details how to either fill out the form online and submit it online, or print out a blank version of the form and fill it out by hand.

**Part A**, starting on page 2, explains how to fill out and sign the form online and submit it online.

**Part B**, starting on page 7, explains how to print out a blank version of the form and fill it out by hand. Note, however, that the NYIA website states that “[t]o designate someone as your authorized representative, you must complete the Authorized Representative section of the NYIA Information Sharing Consent Form, which *must be completed and submitted online*.”<sup>1</sup>

**For more information and updates on NYIA, see:**

<http://www.wnyc.com/health/news/85/> and  
[https://www.health.ny.gov/health\\_care/medicaid/redesign/nyia/](https://www.health.ny.gov/health_care/medicaid/redesign/nyia/)  
<https://nyia.com/en> or Spanish <https://nyia.com/es>

**For Help** – See: <http://www.wnyc.com/health/entry/234/> for where to go for information and advocacy in NYS

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<sup>1</sup> <https://nyia.com/en/consent> (emphasis added).

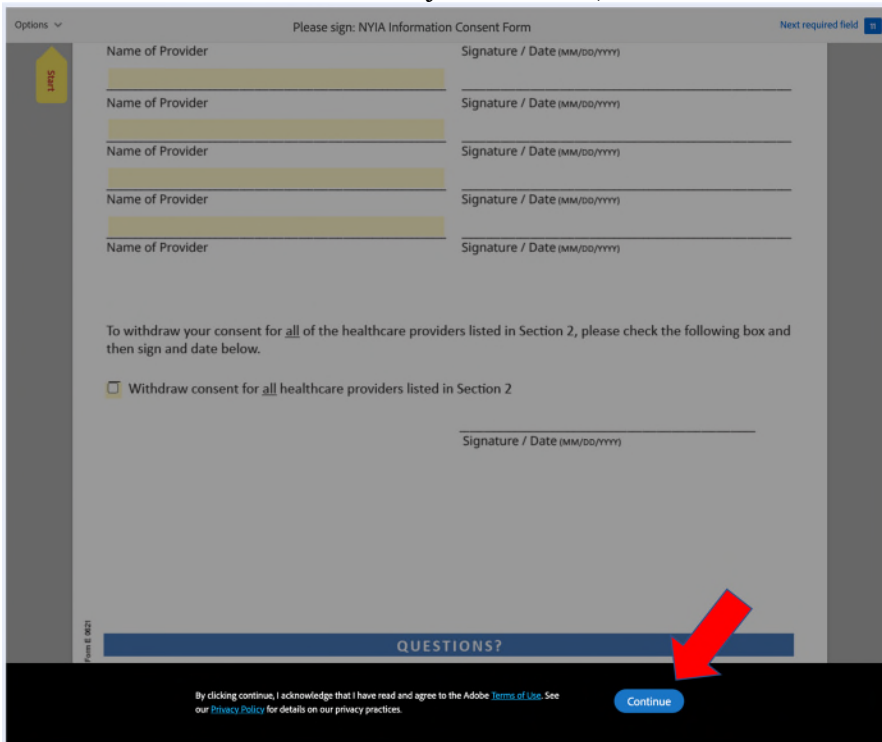
## Part A – Complete the Form Online

In some of the screenshots of the form included below, we have inserted **red arrows** (➔) as visual aids. When you go to the NYIA website on your own computer, you will not see the red arrows. However, you will see yellow arrows (➔) on your own computer, as these are built into the online form.


Also, all required fields are marked with a **red asterisk** (\*). Other fields are highlighted, but are not necessarily required.

### Step 1 – Open the Form

Scroll down to the bottom of your screen, and click: . (screenshot below)

A screenshot of the NYIA Information Consent Form. The form is titled "Please sign: NYIA Information Consent Form" and has a "Next required field" indicator in the top right. The form contains five rows of input fields for "Name of Provider" and "Signature / Date (MM/DD/YYYY)". Below these is a section for withdrawing consent, with a checkbox and a signature/date line. At the bottom, there is a "QUESTIONS?" link and a "Continue" button. A red arrow points to the "Continue" button. The form is currently shaded grey.

### Step 2 – Complete the Form

After you click: , the form, which was previously shaded grey, will become white. Now scroll up to the top of the document to begin filling it in. Required fields will have **red asterisks** (\*). (screenshot below)

The screenshot shows the top portion of the NYIA Information Consent Form. At the top right, a blue box indicates 'Next required field 11'. A red arrow points to this box. The form title is 'New York Independent Assessor Information Sharing Consent Form'. Below the title, there is a paragraph explaining the purpose of the form and a list of four purposes. The form is divided into two main sections: 'INDIVIDUAL'S IDENTIFYING INFORMATION' and 'AUTHORIZED REPRESENTATIVE (IF APPLICABLE)'. The first section contains fields for Last Name, First Name, Middle Initial, DOB, Medicaid ID, Social Security Number, Address, Telephone Number (Landline/Mobile), City, State, Zip Code, and Email Address. The second section contains fields for Last Name, First Name, Middle Initial, Relationship to Individual, Address, City, State, Zip Code, Telephone Number (Landline/Mobile), and Email Address. A yellow 'Start' button is visible on the left side of the form.

There are **11 required fields**. Before you have filled in any of them, the top right-hand corner of the form will read: **Next required field 11**. As you fill out the required fields on the form, this number will automatically lower.

Note: if you opt to start filling in a non-required section of the form, however, it will *become* required, so you will need to either complete all of the fields in that section, or delete all text from that section so it is no longer required.

The first 9 required fields appear on page 1 of the form. Required field #10 appears on page 2 of the form; required field #11 appears on page 3 of the form.

The **required fields** with corresponding numbers are:

1. Last Name
2. First Name
3. Date of Birth
4. Medicaid ID **and/or** Social Security Number - you must fill in at least one
  - a. Note: You must also manually click the bubble next to whichever one you fill in. *The form will not automatically fill in the bubble next to a field simply because you type there – you must manually click the bubble.*

- b. After you click on a bubble, it will convert from white to **blue**. E.g.,:

Medicaid ID    Social Security Number  
 AB12345C     123-45-6789

5. Address (House Number and Street)

6. Telephone Number: Landline or Mobile

- a. Note: as above, you must manually click on the bubble indicating which phone number you will fill in. Here, however, you cannot click both.
- b. Below is an example of the bubble indicating that you are entering a Landline, along with the Landline number to the right of where it reads “Mobile.”

Telephone Number  
 Landline     Mobile    555-555-5555

7. City

8. State

9. Zip Code

10. Individual’s Signature, authorizing the release of medical information

- a. Note: This must be signed by the individual, not their representative, unless the representative is someone designated as such through another legal document, such as a Power of Attorney.

11. Healthcare Provider’s Name

- a. Note: When you enter in text into this field, all of the other fields in this section become required, one-by-one. So you will need to also fill out: “Medical Group/Practice Name,” “Telephone Number,” “Address,” “City,” “State,” “Zip Code” and (at the bottom of this box) “Individual's or Legally Authorized Representative's Signature.”

### Step 3 – Double Check for Completeness

If you missed a required field along the way, the top right corner of the form will tell you how many fields you missed. So if, for example, you have completed all but one

field, the top-right corner will read, in **blue text**:

Next required field **1**

Once you have filled out all required fields, the top right corner of your screen will read, in grey text: 


**WARNING:** We recommend that you leave the very last section of the form, on the bottom of page 6, blank. If you fill it out, it will remove your consent to share information with the providers you listed in Section 2. (screenshot below)

To withdraw your consent for all of the healthcare providers listed in Section 2, please check the following box and then sign and date below.

Withdraw consent for all healthcare providers listed in Section 2

\_\_\_\_\_  
Signature / Date (MM/DD/YYYY)

### Step 4 – Submit the Form Online

Once you have followed Steps 1-3 above and filled out all fields (and not before), the bottom of the document will show you a submission option. Check the box on the left side of the bottom of your screen, and click:  on the right side of the bottom of your screen. (screenshot below)



Options ▾ Please sign: NYIA Information Consent Form Required fields completed ✓

Name of Provider \_\_\_\_\_ Signature / Date (MM/DD/YYYY) \_\_\_\_\_  
Name of Provider \_\_\_\_\_ Signature / Date (MM/DD/YYYY) \_\_\_\_\_  
Name of Provider \_\_\_\_\_ Signature / Date (MM/DD/YYYY) \_\_\_\_\_

To withdraw your consent for all of the healthcare providers listed in Section 2, please check the following box and then sign and date below.



Withdraw consent for all healthcare providers listed in Section 2

\_\_\_\_\_  
Signature / Date (MM/DD/YYYY)

**QUESTIONS?**

If you have questions about this form, call 855-222-8350 TTY: 1-888-329-1541  
Monday to Friday from 8:30 am to 8:00 pm, Saturday from 10:00 am to 6:00 pm

By signing, I agree to this agreement, the [Consumer Disclosure](#) and to do business electronically with Nassau Digital Forms. 

Once you check the box and click: , your screen will show a pop-up window that asks you to enter in your email address. Once you enter in your email address, you can finally click: . (screenshot below)

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### Enter Your Information ×

Please enter your email and then click to sign this document.

Cancel

Click to sign

### Step 5 – Save a Copy of the Form You are Submitting Online, for Your Records

After e-signing the form, you will see a new window that reads:  **You're all set**, confirming that the form has been submitted. (screenshot below) If you want a copy of the e-signed form with all the answers you just filled out, click: [download a copy](#). This will download a PDF copy onto your computer (automatically titled “NYIA Information Consent Form\_encrypted\_.pdf”).

**WARNING:** As soon as you exit out of the window, the form will automatically refresh itself and you will **no longer be able to download** a copy of the form with all of the answers you just filled out. So if you want to download a copy, make sure to do that **before** you exit out of the window. Otherwise, if you want to download a copy of a completed form, you will have to fill the form out all over again.

 **You're all set**

Thank you for signing NYIA Information Consent Form  
You can also [download a copy](#) of what you just signed.

**See next page for how to download a blank copy of the form as a PDF, to print and then fill it out by hand.** Or just print out the blank form attached.


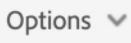
But – be warned that as of July 7, 2022, NYIA has not provided a means to submit a completed form signed manually.

**Part B – How to download a blank copy of the form as a PDF, to print and then fill it out by hand**

As noted above, the NYIA website explicitly states that “[t]o designate someone as your authorized representative, you must complete the Authorized Representative section of the NYIA Information Sharing Consent Form, which *must be completed and submitted online.*”<sup>2</sup> Therefore, if you wish to designate a representative, it is unclear if you can submit the form as a paper copy, even if you were to print out a blank version and fill it out by hand. If the consumer cannot e-sign a form online, however, and does not wish to designate a representative, here are instructions to download a blank copy of the form for the consumer to print, and then fill out and sign by hand. Or – just print out a copy of the PDF blank form attached to this fact sheet.

Follow **Part A, Step 1** on page 1-2 above to find and open the form on the computer.

**Step 1 – Scroll Up to the Top**

After you click: , the form, which was previously shaded grey, will become white. Make sure to scroll up to the top of the document so you can see: . (screenshot below)

Options ▾ Please sign: NYIA Information Consent Form Next required field

**New York Independent Assessor** Information Sharing Consent Form  
New York State Assessment Program in collaboration with New York Medicaid Choice

By completing this form, the individual or authorized representative authorizes the release of the individual's protected health information (PHI) to the New York Independent Assessor (NYIA). The NYIA will contact the healthcare providers identified on this form to obtain the PHI. The NYIA will use and share the PHI with the Independent Practitioner Panel (IPP) and the Independent Review Panel (IRP) for the following purposes:

- 1) Assessing the individual's need for Community Based Long Term Services and Supports (CBLTSS), including personal care services (PCS) and Consumer Directed Personal Assistance Services (CDPAS);
- 2) Determining the individual's eligibility for enrollment into a Managed Long Term Care (MLTC) plan;
- 3) Developing the Community Health Assessment (CHA), Practitioner Order (PO), and IRP recommendations, as applicable, to assist the individual's Managed Care Organization (MCO) or Local Department of Social Services (LDSS) in developing a Plan of Care and service authorization; and
- 4) Treatment, payment and/or healthcare operations, or as permitted under the law.

**INDIVIDUAL'S IDENTIFYING INFORMATION**

Last Name	First Name	Middle Initial	DOB (MM/DD/YYYY)
Medicaid ID	Social Security Number		
Address (No. and Street)		Telephone Number	
		Landline Mobile	
City	State	Zip Code	Email Address

**AUTHORIZED REPRESENTATIVE (IF APPLICABLE)**

Last Name	First Name	Middle Initial	Relationship to Individual	
Address (No. and Street)		City	State	Zip Code
Telephone Number		Email Address		
Landline Mobile				

Start Options ▾

<sup>2</sup> <https://nyia.com/en/consent> (emphasis added).



## Step 2 – Convert the Document to a PDF

Click on the top left-hand corner, where it reads: **Options** . (screenshot below)

Options Please sign: NYIA Information Consent Form Next required field 1

**New York Independent Assessor** Information Sharing Consent Form

By completing this form, the individual or authorized representative authorizes the release of the individual's protected health information (PHI) to the New York Independent Assessor (NYIA). The NYIA will contact the healthcare providers identified on this form to obtain the PHI. The NYIA will use and share the PHI with the Independent Practitioner Panel (IPP) and the Independent Review Panel (IRP) for the following purposes:

- 1) Assessing the individual's need for Community Based Long Term Services and Supports (CBLTSS), including personal care services (PCS) and Consumer Directed Personal Assistance Services (CDPAS);
- 2) Determining the individual's eligibility for enrollment into a Managed Long Term Care (MLTC) plan;
- 3) Developing the Community Health Assessment (CHA), Practitioner Order (PO), and IRP recommendations, as applicable, to assist the individual's Managed Care Organization (MCO) or Local Department of Social Services (LDSS) in developing a Plan of Care and service authorization; and
- 4) Treatment, payment and/or healthcare operations, or as permitted under the law.

**INDIVIDUAL'S IDENTIFYING INFORMATION**

Last Name *	First Name *	Middle Initial	DOB (MM/DD/YYYY) *
Medicaid ID		Social Security Number	
Address (No. and Street) *		Telephone Number	
		<input type="checkbox"/> Landline <input type="checkbox"/> Mobile	
City *	State *	Zip Code *	Email Address

**AUTHORIZED REPRESENTATIVE (IF APPLICABLE)**

Last Name	First Name	Middle Initial	Relationship to Individual	
Address (No. and Street)		City	State	Zip Code
Telephone Number		Email Address		
<input type="checkbox"/> Landline <input type="checkbox"/> Mobile				

From the drop-down menu that appears, select: **Read agreement** . (screenshot below)


Options ▾

- Read agreement
- Clear document data

The form will turn into a downloadable PDF. It will now read: **Adobe Acrobat Sign** in the top left corner of the document. (screenshot below)



Adobe Acrobat Sign NYIA Information Consent Form Sign In

 **Information Sharing Consent Form**  
New York State's Assessment Program in collaboration with New York Medicaid Choice

By completing this form, the individual or authorized representative authorizes the release of the individual's protected health information (PHI) to the New York Independent Assessor (NYIA). The NYIA will contact the healthcare providers identified on this form to obtain the PHI. The NYIA will use and share the PHI with the Independent Practitioner Panel (IPP) and the Independent Review Panel (IRP) for the following purposes:

- 1) Assessing the individual's need for Community Based Long Term Services and Supports (CBLTSS), including personal care services (PCS) and Consumer Directed Personal Assistance Services (CDPAS);
- 2) Determining the individual's eligibility for enrollment into a Managed Long Term Care (MLTC) plan;
- 3) Developing the Community Health Assessment (CHA), Practitioner Order (PO), and IRP recommendations, as applicable, to assist the individual's Managed Care Organization (MCO) or Local Department of Social Services (LDSS) in developing a Plan of Care and service authorization; and
- 4) Treatment, payment and/or healthcare operations, or as permitted under the law.

**INDIVIDUAL'S IDENTIFYING INFORMATION**

Last Name	First Name	Middle Initial	DOB (MM/DD/YYYY)
Medicaid ID <input type="radio"/>		Social Security Number <input type="radio"/>	
Address (No. and Street)		Telephone Number <input type="radio"/> Landline <input type="radio"/> Mobile	
City	State	Zip Code	Email Address


**AUTHORIZED REPRESENTATIVE (IF APPLICABLE)**

Last Name	First Name	Middle Initial	Relationship to Individual
Address (No. and Street)		City	State
Telephone Number <input type="checkbox"/> Landline <input type="checkbox"/> Mobile		Zip Code	
		Email Address	

*This form must be completed by the individual or a legally authorized representative. For the purpose of sharing health information, a legally authorized representative is defined as "a person or agency authorized by state,*

1 / 6

### Step 3 – Download the PDF

The standard PDF options (zoom in and zoom out, reload, etc.) will show up at the bottom of your screen. The download icon is near the right and looks like . Click this, and it will down the form as a blank PDF, automatically titled “NYIA Information Consent Form.pdf.”

### Step 4 – Fill out the PDF by hand

Once you have printed a blank form, you can fill it out and sign it by hand. We will update this fact sheet if we learn how to submit a manually signed form.

**WARNING:** We recommend that you leave the very last section of the form, on the bottom of page 6, blank. If you fill it out, it will remove your consent to share information with the providers you listed in Section 2. (screenshot below)

To withdraw your consent for all of the healthcare providers listed in Section 2, please check the following box and then sign and date below.

Withdraw consent for all healthcare providers listed in Section 2

\_\_\_\_\_  
Signature / Date (MM/DD/YYYY)

=====  
This fact sheet posted at <http://www.wnyc.com/health/download/817/> (July 7, 2022)  
--Check there for updates --

**For more information and updates on NYIA, see:**

<http://www.wnyc.com/health/news/85/> &

[https://www.health.ny.gov/health\\_care/medicaid/redesign/nyia/](https://www.health.ny.gov/health_care/medicaid/redesign/nyia/)

<https://nyia.com/en> or Spanish <https://nyia.com/es>

**For Help** – See: <http://www.wnyc.com/health/entry/232/#Get%20Help>

**COPY OF FILLABLE FORM ATTACHED**



By completing this form, the individual or authorized representative authorizes the release of the individual's protected health information (PHI) to the New York Independent Assessor (NYIA). The NYIA will contact the healthcare providers identified on this form to obtain the PHI. The NYIA will use and share the PHI with the Independent Practitioner Panel (IPP) and the Independent Review Panel (IRP) for the following purposes:

- 1) Assessing the individual's need for Community Based Long Term Services and Supports (CBLTSS), including personal care services (PCS) and Consumer Directed Personal Assistance Services (CDPAS);
- 2) Determining the individual's eligibility for enrollment into a Managed Long Term Care (MLTC) plan;
- 3) Developing the Community Health Assessment (CHA), Practitioner Order (PO), and IRP recommendations, as applicable, to assist the individual's Managed Care Organization (MCO) or Local Department of Social Services (LDSS) in developing a Plan of Care and service authorization; and
- 4) Treatment, payment and/or healthcare operations, or as permitted under the law.

**INDIVIDUAL'S IDENTIFYING INFORMATION**

Last Name		First Name		Middle Initial	DOB (MM/DD/YYYY)
Medicaid ID <input type="radio"/>			Social Security Number <input type="radio"/>		
Address (No. and Street)			Telephone Number <input type="radio"/> Landline <input type="radio"/> Mobile		
City	State	Zip Code	Email Address		

**AUTHORIZED REPRESENTATIVE (IF APPLICABLE)**

Last Name		First Name		Middle Initial	Relationship to Individual
Address (No. and Street)			City	State	Zip Code
Telephone Number <input type="checkbox"/> Landline <input type="checkbox"/> Mobile		Email Address			

*This form must be completed by the individual or a legally authorized representative. For the purpose of sharing health information, a legally authorized representative is defined as "a person or agency authorized by state, tribal, military or other applicable law, court order or consent to act on behalf of a person for the release of medical information."*

**INSTRUCTIONS FOR THE INDIVIDUAL/AUTHORIZED REPRESENTATIVE**

**SECTION 1:** This section lists the health information your current healthcare providers can share with the NYIA, the IPP, and the IRP. This information will be used for the development of the CHA and PO, and by the IRP to evaluate your needs for CBLTSS and eligibility for MLTC plan enrollment.

**SECTION 2:** In this section, you will list all the healthcare providers who can share your health information. The health information they share may be from before and after the date this form was signed.

**SECTION 3:** This section can be used to withdraw your consent to share health information from any of the healthcare providers listed in Section 2.

## SECTION 1. RELEASE OF MEDICAL INFORMATION

By completing this Consent Form, I agree and understand that:

- Each provider listed in Section 2 of this form may share my health information with the NYIA, the IPP, and the IRP, and the NYIA, IPP, and IRP may share my health information with each other.
- The purposes for sharing my health information are to: 1) evaluate my needs for CBLTSS, 2) determine eligibility for MLTC plan enrollment and 3) assist in the development of my Plan of Care.
- My health information includes all my medical records, including medications, clinical records, diagnoses, and treatment plans from the 12-month period before the records request from NYIA. My health information also includes any records or information related to current diagnoses, including but not limited to any determination of serious mental illness, Alzheimer's and dementia.
- If there are no medical records from within this 12-month period, providers may share documentation related to the most recent physician visit, emergency room visit, hospitalization, or other encounter with the providers.
- Once disclosed, my health information may be shared by the NYIA, IPP, and IRP for the purposes indicated on this form.
- I can also authorize providers to disclose alcohol and drug treatment, mental health treatment, or confidential HIV/AIDS-related information to the NYIA, IPP, and IRP. I can do this by placing my initials next to the specific information I want disclosed in Section 2. I can also give my authorization to some providers and not others.
- If I authorize the disclosure of any alcohol and drug treatment, mental health treatment, or confidential HIV/AIDS-related information, the NYIA, IPP, and IRP may not redisclose it, or use it for other purposes, without my additional authorization unless permitted or required under federal or state law.
- This consent will stay in place until I am no longer enrolled in an applicable health plan or in receipt of CBLTSS. I can also withdraw my consent for any or all providers I list in Section 2 by using Section 3 of this form.

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Name of Individual or Legally Authorized Representative (please print)

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Legally Authorized Representative's Relationship to Individual

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Signature

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Date (MM/DD/YYYY)

## SECTION 2. PROVIDERS WHO MAY SHARE MY INFORMATION

Please list the providers you authorize to release your medical information. You must sign your name under each provider entry.

Healthcare Provider's Name			
Medical Group/Practice Name		Telephone Number	
Address	City	State	Zip Code
<p><b>MEDICAL DISCLOSURE INFORMATION.</b> In accordance with the terms of Section 1 of this form, you are giving your permission and direction to this healthcare provider to disclose your health information to the NYIA, IPP and/or IRP. This consent will stay in place until you are no longer enrolled in an applicable health plan or in receipt of CBLTSS. If you do not want your consent for sharing health information to last that long, please provide a different end date or event here: _____.</p> <p>You can also withdraw your consent for any or all providers you list in Section 2 by using Section 3 ("Provider Consent Withdrawals/ Modifications") of this form.</p>			
<p><b>Place your initials next to each type of health information below that you wish to be disclosed. If you want, you can specify exactly what information you want to be disclosed next to each line below. You can also specify an end date or event for when this information may be disclosed (this can be different than the end date or event that applies to your other health information).</b></p>			
<i>Initial Below</i>		<i>Information to be Disclosed</i>	
_____		Records from alcohol/drug treatment programs	
_____		Clinical records from mental health programs	
_____		HIV/AIDS-related Information	
Individual's or Legally Authorized Representative's Signature			Date: (MM/DD/YYYY)

Healthcare Provider's Name			
Medical Group/Practice Name		Telephone Number	
Address	City	State	Zip Code
<p><b>MEDICAL DISCLOSURE INFORMATION.</b> In accordance with the terms of Section 1 of this form, you are giving your permission and direction to this healthcare provider to disclose your health information to the NYIA, IPP and/or IRP. This consent will stay in place until you are no longer enrolled in an applicable health plan or in receipt of CBLTSS. If you do not want your consent for sharing health information to last that long, please provide a different end date or event here: _____.</p> <p>You can also withdraw your consent for any or all providers you list in Section 2 by using Section 3 ("Provider Consent Withdrawals/ Modifications") of this form.</p>			
<p><b>Place your initials next to each type of health information below that you wish to be disclosed. If you want, you can specify exactly what information you want to be disclosed next to each line below. You can also specify an end date or event for when this information may be disclosed (this can be different than the end date or event that applies to your other health information).</b></p>			
<i>Initial Below</i>		<i>Information to be Disclosed</i>	
_____		Records from alcohol/drug treatment programs	
_____		Clinical records from mental health programs	
_____		HIV/AIDS-related Information	
Individual's or Legally Authorized Representative's Signature			Date: (MM/DD/YYYY)

## SECTION 2. PROVIDERS WHO MAY SHARE MY INFORMATION

Please list the providers you authorize to release your medical information. You must sign your name under each provider entry.

Healthcare Provider's Name			
Medical Group/Practice Name		Telephone Number	
Address	City	State	Zip Code
<p><b>MEDICAL DISCLOSURE INFORMATION.</b> In accordance with the terms of Section 1 of this form, you are giving your permission and direction to this healthcare provider to disclose your health information to the NYIA, IPP and/or IRP. This consent will stay in place until you are no longer enrolled in an applicable health plan or in receipt of CBLTSS. If you do not want your consent for sharing health information to last that long, please provide a different end date or event here: _____.</p> <p>You can also withdraw your consent for any or all providers you list in Section 2 by using Section 3 ("Provider Consent Withdrawals/ Modifications") of this form.</p>			
<p><b>Place your initials next to each type of health information below that you wish to be disclosed. If you want, you can specify exactly what information you want to be disclosed next to each line below. You can also specify an end date or event for when this information may be disclosed (this can be different than the end date or event that applies to your other health information).</b></p>			
<i>Initial Below</i>		<i>Information to be Disclosed</i>	
_____		Records from alcohol/drug treatment programs	
_____		Clinical records from mental health programs	
_____		HIV/AIDS-related Information	
Individual's or Legally Authorized Representative's Signature			Date: (MM/DD/YYYY)

Healthcare Provider's Name			
Medical Group/Practice Name		Telephone Number	
Address	City	State	Zip Code
<p><b>MEDICAL DISCLOSURE INFORMATION.</b> In accordance with the terms of Section 1 of this form, you are giving your permission and direction to this healthcare provider to disclose your health information to the NYIA, IPP and/or IRP. This consent will stay in place until you are no longer enrolled in an applicable health plan or in receipt of CBLTSS. If you do not want your consent for sharing health information to last that long, please provide a different end date or event here: _____.</p> <p>You can also withdraw your consent for any or all providers you list in Section 2 by using Section 3 ("Provider Consent Withdrawals/ Modifications") of this form.</p>			
<p><b>Place your initials next to each type of health information below that you wish to be disclosed. If you want, you can specify exactly what information you want to be disclosed next to each line below. You can also specify an end date or event for when this information may be disclosed (this can be different than the end date or event that applies to your other health information).</b></p>			
<i>Initial Below</i>		<i>Information to be Disclosed</i>	
_____		Records from alcohol/drug treatment programs	
_____		Clinical records from mental health programs	
_____		HIV/AIDS-related Information	
Individual's or Legally Authorized Representative's Signature			Date: (MM/DD/YYYY)

## SECTION 2. PROVIDERS WHO MAY SHARE MY INFORMATION

Please list the providers you authorize to release your medical information. You must sign your name under each provider entry.

Healthcare Provider's Name			
Medical Group/Practice Name		Telephone Number	
Address	City	State	Zip Code
<p><b>MEDICAL DISCLOSURE INFORMATION.</b> In accordance with the terms of Section 1 of this form, you are giving your permission and direction to this healthcare provider to disclose your health information to the NYIA, IPP and/or IRP. This consent will stay in place until you are no longer enrolled in an applicable health plan or in receipt of CBLTSS. If you do not want your consent for sharing health information to last that long, please provide a different end date or event here: _____.</p> <p>You can also withdraw your consent for any or all providers you list in Section 2 by using Section 3 ("Provider Consent Withdrawals/ Modifications") of this form.</p>			
<p><b>Place your initials next to each type of health information below that you wish to be disclosed. If you want, you can specify exactly what information you want to be disclosed next to each line below. You can also specify an end date or event for when this information may be disclosed (this can be different than the end date or event that applies to your other health information).</b></p>			
<i>Initial Below</i>		<i>Information to be Disclosed</i>	
_____		Records from alcohol/drug treatment programs	
_____		Clinical records from mental health programs	
_____		HIV/AIDS-related Information	
Individual's or Legally Authorized Representative's Signature			Date: (MM/DD/YYYY)

Healthcare Provider's Name			
Medical Group/Practice Name		Telephone Number	
Address	City	State	Zip Code
<p><b>MEDICAL DISCLOSURE INFORMATION.</b> In accordance with the terms of Section 1 of this form, you are giving your permission and direction to this healthcare provider to disclose your health information to the NYIA, IPP and/or IRP. This consent will stay in place until you are no longer enrolled in an applicable health plan or in receipt of CBLTSS. If you do not want your consent for sharing health information to last that long, please provide a different end date or event here: _____.</p> <p>You can also withdraw your consent for any or all providers you list in Section 2 by using Section 3 ("Provider Consent Withdrawals/ Modifications") of this form.</p>			
<p><b>Place your initials next to each type of health information below that you wish to be disclosed. If you want, you can specify exactly what information you want to be disclosed next to each line below. You can also specify an end date or event for when this information may be disclosed (this can be different than the end date or event that applies to your other health information).</b></p>			
<i>Initial Below</i>		<i>Information to be Disclosed</i>	
_____		Records from alcohol/drug treatment programs	
_____		Clinical records from mental health programs	
_____		HIV/AIDS-related Information	
Individual's or Legally Authorized Representative's Signature			Date: (MM/DD/YYYY)



### SECTION 3. PROVIDER CONSENT WITHDRAWALS/MODIFICATIONS

Complete this section to withdraw your consent for any or all healthcare providers listed in Section 2 of this form.

To withdraw your consent for specific healthcare providers, list providers individually and sign and date next to each.

\_\_\_\_\_  
Name of Provider

\_\_\_\_\_  
Signature / Date (MM/DD/YYYY)

\_\_\_\_\_  
Name of Provider

\_\_\_\_\_  
Signature / Date (MM/DD/YYYY)

\_\_\_\_\_  
Name of Provider

\_\_\_\_\_  
Signature / Date (MM/DD/YYYY)

\_\_\_\_\_  
Name of Provider

\_\_\_\_\_  
Signature / Date (MM/DD/YYYY)

\_\_\_\_\_  
Name of Provider

\_\_\_\_\_  
Signature / Date (MM/DD/YYYY)

\_\_\_\_\_  
Name of Provider

\_\_\_\_\_  
Signature / Date (MM/DD/YYYY)

To withdraw your consent for all of the healthcare providers listed in Section 2, please check the following box and then sign and date below.

Withdraw consent for all healthcare providers listed in Section 2

\_\_\_\_\_  
Signature / Date (MM/DD/YYYY)

### QUESTIONS?

If you have questions about this form, call 855-222-8350 TTY: 1-888-329-1541  
Monday to Friday from 8:30 am to 8:00 pm, Saturday from 10:00 am to 6:00 pm