

<u>"How To" Guide for the New York Independent Assessor (NYIA)</u> <u>Information Sharing Consent Form for Authorized Representatives</u> Prepared by Evelyn Frank Legal Resources Program (EFLRP) <u>eflrp@nylag.org</u>

This fact sheet is posted at <u>http://www.wnylc.com/health/download/817/</u> 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 <u>https://nyia.com/en/consent</u> . 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*."¹

For more information and updates on NYIA, see: <u>http://www.wnylc.com/health/news/85/</u> and <u>https://www.health.ny.gov/health_care/medicaid/redesign/nyia/</u> <u>https://nyia.com/en or Spanish https://nyia.com/es</u>

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

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

Part A – Complete the Form Online

In some of the screenshots of the form included below, we have inserted red arrows (\rightarrow) 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 (\rightarrow) 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.

Please sig	n: NYIA Information Consent Form Next req	aired field n
Name of Provider	Signature / Date (MM/DD/YYYY)	
Name of Provider	Signature / Date (MM/DD/YYY)	
Name of Provider	Signature / Date (MM/D0/YYY)	
Name of Provider	Signature / Date (MM/D0/YYY)	
Name of Provider	Signature / Date (MM/D0/YYYY)	
then sign and date below.	nealthcare providers listed in Section 2, please check the following box and	
then sign and date below.	providers listed in Section 2	
then sign and date below.	providers listed in Section 2	
then sign and date below.	providers listed in Section 2	

Step 1 – Open the Form

Step 2 – Complete the Form

After you click: Continue, 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)

~		Please sign: NY	YIA Informati	on Consent Form				Next required field
	New York Independer		formati aring C	on onsent For	m			
	By completing this form, protected health informa healthcare providers ider Independent Practitioner 1) Assessing the individu personal care services	ation (PHI) to the Ne ntified on this form t r Panel (IPP) and the al's need for Comm	ew York Inde to obtain the Independe unity Based	ependent Assess he PHI. The NYIA ent Review Panel Long Term Servi	or (NYIA). The will use and s I (IRP) for the f ices and Supp	NYIA with hare the following orts (CBL	l contact the PHI with the purposes:	
	2) Determining the indivi	idual's eligibility for	enrollment	into a Managed	Long Term Ca	re (MLTC		
	 Developing the Comm applicable, to assist th 	iunity Health Assess ie individual's Manag	ged Care O					
	(LDSS) in developing a							
	(LDSS) in developing a 4) Treatment, payment a INDIVIDUAL'S IDENTIF	nd/or healthcare op	perations, o					
Start	(LDSS) in developing a 4) Treatment, payment a	nd/or healthcare op	perations, o		nder the law. Middle Initial	DOB (MM	1/DD/YYYY)	
itart	(LDSS) in developing a 4) Treatment, payment a INDIVIDUAL'S IDENTIF	nd/or healthcare op	perations, o	r as permitted u		DOB (MN	/bb/mm)	
itart	(LDSS) in developing a 4) Treatment, payment a INDIVIDUAL'S IDENTIF Last Name *	nd/or healthcare op	perations, o	r as permitted u	Middle Initial ecurity Number	ров (мм	//bb/mm)	
itart	(LDSS) in developing a 4) Treatment, payment a INDIVIDUAL'S IDENTIF Last Name * Medicaid ID	nd/or healthcare op	perations, o	social Se Telephone Nu Landline	Middle Initial ecurity Number imber Mobile	DOB (MN	yaa/wwy	
itart	(LDSS) in developing a 4) Treatment, payment a INDIVIDUAL'S IDENTIF Last Name * Medicaid ID Address (No. and Street) * City *	And/or healthcare op YING INFORMATION F * State *	Perations, o ON First Name Tirst Name Tirst Name	social Se Telephone Nu Landline	Middle Initial ecurity Number imber Mobile	DOB (MN	/00/YYYY]	
itart	(LDSS) in developing a 4) Treatment, payment a INDIVIDUAL'S IDENTIF Last Name * Medicaid ID Address (No. and Street) *	And/or healthcare op YING INFORMATION F * State *	Zip Code	social Se Telephone Nu Landline	Middle Initial ecurity Number imber Mobile	*	נוסוגאוין to Individu	Ial
itart	(LDSS) in developing a 4) Treatment, payment a INDIVIDUAL'S IDENTIF Last Name * Medicaid ID Address (No. and Street) * City * AUTHORIZED REPRESE	ING INFORMATIO	Zip Code	social Se Telephone Nu Landline	Middle Initial ecurity Number Mobile	*		
itart	(LDSS) in developing a 4) Treatment, payment a INDIVIDUAL'S IDENTIF Last Name * Medicaid ID O Address (No. and Street) * City * AUTHORIZED REPRESE Last Name	ING INFORMATIO	Zip Code	r as permitted un Social Se Telephone Nu Ernail Addre	Middle Initial ecurity Number Mobile	*	tionship to Individu	Ial

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 field 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 <u>and/or</u> Social Security Number you must fill in <u>at least</u> one
 - a. Note: You must also manually click the bubble next to whichever one you fill in. *The form will <u>not</u> automatically fill in the bubble next to a field simply because you type there you must <u>manually</u> 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 <u>or</u> 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 Iandline $^{\bigcirc}$ 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."

Next required field

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:

Once you have filled out all required fields, the top right corner of your screen will

read, in grey text: Required fields completed 🥥

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 an	d
then sign and date below.	

□ Withdraw consent for <u>all</u> 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: Click to Sign on the right side of the bottom of your screen. (screenshot below)



Once you check the box and click: Click to Sign, 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: Click to Sign. (screenshot below)

Enter Your Information	×
Please enter your email and then click to sign this document.	
test@test.com	
	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.



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.

<u>Part B – How to download a blank copy of the form as a PDF, to print</u> 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*."² 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 ot 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	C

After you click: Continue, 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: Options \checkmark (screenshot below)

		Please sign	n: NYIA	Informatio	on Consent Form					Next required	
	New York Independent Assessor Sharing Consent Form										
	By completing this form protected health inform healthcare providers id Independent Practition 1) Assessing the individ personal care service	nation (PHI) to the entified on this fo er Panel (IPP) and lual's need for Con	e New orm to d the In mmuni	York Inde obtain th ndepende ity Based	ependent Assess e PHI. The NYIA ent Review Pane Long Term Serv	sor (NYIA). The will use and s I (IRP) for the rices and Supp	e NYIA share follow orts (A will co the PH ving pu CBLTSS	ontact the II with the irposes:		
	2) Determining the indi								lan;		
	 Developing the Com 										
	 Beveloping the Commapplicable, to assist t (LDSS) in developing Treatment, payment 	the individual's M a Plan of Care an and/or healthcar	lanager id servi re oper	d Care Or ice author rations, or	ganization (MCO rization; and	O) or Local Dep					
	applicable, to assist t (LDSS) in developing	the individual's M a Plan of Care an and/or healthcar	lanager id servi re oper	d Care Or ice author rations, or	ganization (MCO rization; and	O) or Local Dep	partm		Social Service		
rt	applicable, to assist t (LDSS) in developing 4) Treatment, payment INDIVIDUAL'S IDENTI	the individual's M a Plan of Care an and/or healthcar	lanager id servi re oper	d Care Or ice author ations, or	ganization (MCC rization; and r as permitted u	O) or Local Dep inder the law.	partm	ient of	Social Service		
n	applicable, to assist t (LDSS) in developing 4) Treatment, payment INDIVIDUAL'S IDENTI Last Name Medicaid ID	the individual's M a Plan of Care an and/or healthcar	lanager id servi re oper	d Care Or ice author ations, or	ganization (MCC rization; and r as permitted u Social S	O) or Local Dep inder the law. Middle Initial	partm	ient of	Social Service		
n	applicable, to assist t (LDSS) in developing 4) Treatment, payment INDIVIDUAL'S IDENTI Last Name	the individual's M a Plan of Care an and/or healthcar	lanager id servi re oper	d Care Or ice author ations, or	ganization (MCC rization; and r as permitted u Social S Social S C Telephone N	O) or Local Dep inder the law. Middle Initial iecurity Number umber Mobile	partm	ient of	Social Service		
•	applicable, to assist t (LDSS) in developing 4) Treatment, payment INDIVIDUAL'S IDENTI Last Name Medicaid ID	the individual's M a Plan of Care an and/or healthcar	lanager id servi re oper ATION Firs	d Care Or ice author ations, or	ganization (MCC rization; and r as permitted u Social S D Telephone N	O) or Local Dep inder the law. Middle Initial iecurity Number umber Mobile	partm	ient of	Social Service		
rt -	applicable, to assist t (LDSS) in developing 4) Treatment, payment INDIVIDUAL'S IDENTI Last Name Medicaid ID Address (No. and Street) * City *	the individual's M a Plan of Care an and/or healthcar IFYING INFORM State	Anager ad servi re oper ATION Firs *	d Care Or, ice author rations, or N t Name Zip Code	ganization (MCC rization; and r as permitted u Social S Social S C Telephone N	O) or Local Dep inder the law. Middle Initial iecurity Number umber Mobile	partm	ient of	Social Service		
n	applicable, to assist t (LDSS) in developing 4) Treatment, payment INDIVIDUAL'S IDENTI Last Name Medicaid ID Address (No. and Street)	the individual's M a Plan of Care an and/or healthcar IFYING INFORM State SEENTATIVE (IF A	Anager ad servi re oper ATION Firs *	Zip Code *	ganization (MCC rization; and r as permitted u Social S Social S C Telephone N	O) or Local Dep inder the law. Middle Initial iecurity Number umber Mobile	DOB *	I MMVDD	Social Service	5	
n	applicable, to assist t (LDSS) in developing 4) Treatment, payment INDIVIDUAL'S IDENTI Last Name 4 Address (No. and Street) 4 City 4 AUTHORIZED REPRES	the individual's M a Plan of Care an and/or healthcar IFYING INFORM State SEENTATIVE (IF A	Anager d servi re oper ATION First *	Zip Code *	ganization (MCC rization; and r as permitted u Social S Social S C Telephone N	O) or Local Dep inder the law. Middle Initial iecurity Number Mobile ess	DOB *	I MMVDD	Virm	5	

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

Step 2 – Convert the Document to a PDF

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

-	Please sign: NVIA Information Consent Form							
Tex Text Tage	New York Independent Ass	sessor Sha	ormatio	on onsent Forr	m			
protect healthc Indeper 1) Asse persi 2) Dete 3) Deve	pleting this form, the ind ed health information (P are providers identified, and the individual's nee onal care services (PCS) a rmining the individual's of doping the Community H cable, to assist the indivi-	PHI) to the Nev on this form to (IPP) and the ed for Commu and Consumer eligibility for e Health Assessn	w York Inde o obtain th Independe nity Based Directed I enrollment nent (CHA)	pendent Assess e PHI. The NYIA ent Review Panel Long Term Servi Personal Assistan into a Managed , Practitioner Ore	or (NYIA). The will use and si ((IRP) for the f ices and Supp ice Services (C Long Term Ca der (PO), and	NYIA hare t follow orts (0 DPAS re (M IRP re	will contact the he PHI with the ing purposes: (BLTSS), including); LTC) plan;	
(LDS) 4) Treat	S) in developing a Plan of ment, payment and/or b DUAL'S IDENTIFYING I	healthcare ope	erations, o	rization; and				
(LDS) 4) Treat INDIVI Last Na	S) in developing a Plan of tment, payment and/or h DUAL'S IDENTIFYING I	healthcare ope	erations, o	rization; and			(MM/DD/YYYY)	
(LDS 4) Treat	S) in developing a Plan ol Iment, payment and/or h DUAL'S IDENTIFYING I me	healthcare ope	erations, o N	rization; and r as permitted ur	nder the law.		(MM/D0/1999)	
(LDS: 4) Treat INDIVI Last Na Medica	S) in developing a Plan ol Iment, payment and/or h DUAL'S IDENTIFYING I me	healthcare ope	erations, o N	rization; and r as permitted ur	Middle Initial		(MM/DD/YYYY)	
(LDS: 4) Treat INDIVI Last Na Medica	S) in developing a Plan ol tment, payment and/or h DUAL'S IDENTIFYING I me id ID	healthcare ope	erations, o N	rization; and r as permitted un Social Se	Middle Initial		(MM/D0/YYYY)	
(LDS) 4) Treat INDIVI Last Na * Medica Address City *	S) in developing a Plan ol tment, payment and/or h DUAL'S IDENTIFYING I me id ID	INFORMATIO	erations, or DN Irst Name Zip Code	rization; and r as permitted un Social Se Telephone Nu Calendine	Middle Initial		(MM/D0/YYYY)	
(LDS) 4) Treat INDIVI Last Na * Medica Address City *	S) in developing a Plan ol ment, payment and/or F DUAL'S IDENTIFYING I me id ID s (No. and Street) DRIZED REPRESENTATI	INFORMATIO	Zip Code	rization; and r as permitted un Social Se Telephone Nu Calendine	Middle Initial	★ DOB	(MM/DD/YYYY) Relationship to Individu	
(LDS) 4) Treat INDIVI Last Na Addres City AUTHO Last Na	S) in developing a Plan ol ment, payment and/or F DUAL'S IDENTIFYING I me id ID s (No. and Street) DRIZED REPRESENTATI	State	Zip Code	rization; and r as permitted un Social Se Telephone Nu Calendine	Middle Initial scurity Number mber Mobile	★ DOB		

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



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 Informat	tion Consent Fe	orm			Sign In	•
۵	1	New York Independent Assessor New York Name Assessor New York Name Assessor										
		By completing this form, the individ protected health information (PHI) healthcare providers identified on t Independent Practitioner Panel (IPF 1) Assessing the individual's need fi personal care services (PCS) and 2) Determining the individual's eligi 3) Developing the Community Heal applicable, to assist the individua (LDSS) in developing a Plan of Ca 4) Treatment, payment and/or heal INDIVIDUAL'S IDENTIFYING INFO	to the New his form to be commu Consumer bility for e th Assesse l's Manag re and ser thcare ope	w York Inde o obtain the Independen nity Based r Directed P enrollment i ment (CHA), ed Care Org vice author erations, or	Pend PH nt Re Long erso nto Prac ganiz izati	dent Assesso I. The NYIA we eview Panel (g Term Servic nal Assistance a Managed L ctitioner Ord cation (MCO) on; and	or (NYIA). Th vill use and (IRP) for the ces and Supp ce Services (.ong Term C ler (PO), and or Local De	e NYIA share follow ports (CDPA are (N d IRP r spartm	A will o the PH wing p (CBLTS S); MLTC) p recomm	contact the H with the urposes: S), including olan; mendations, as f Social Services		
		Medicaid ID O				Social Sec	curity Number					
		Address (No. and Street)				Telephone Nun Ol Landline O						
		City	State	Zip Code		Email Address	s					
		AUTHORIZED REPRESENTATIVE		CABLE)								
		Last Name	First Nar	me			Middle	Initial	Relatio	onship to Individual		
		Address (No. and Street)			City			State		Zip Code		
		Telephone Number			Emai	l Address						
		This form must be completed by the health information, a legally author										
		Q @	❶_ <u>1</u> /	6 O	Ð	6	C 7	. 📥				

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 <u>all</u> of the healthcare providers listed in Section 2, please check the following box and then sign and date below.

□ Withdraw consent for <u>all</u> healthcare providers listed in Section 2

Signature / Date (MM/DD/YYYY)

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

For more information and updates on NYIA, see:

http://www.wnylc.com/health/news/85/ &

https://www.health.ny.gov/health_care/medicaid/redesign/nyia/

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

 $\label{eq:formula} \textbf{For Help}-See: \underline{http://www.wnylc.com/health/entry/232/\#Get\%20Help}$

COPY OF FILLABLE FORM ATTACHED

New York Information smeet Program in collaboration with New York Medicaid Choice Smeet 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	Firs	First Name			Middle Initial	DOB (MM/DD/YYYY)
Medicaid ID O				Social Se O	curity Number	
Address (No. and Street)				ohone Nur andline O		
City	State	Zip Code	Em	nail Addres	S	

AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

Last Name	First Name		Middle I	nitial	Relatio	nship to Individual
Address (No. and Street)	I	City		State	<u> </u>	Zip Code
Telephone Number		Email Address				
🗆 Landline 🛛 Mobile						

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.

Name of Individual or Legally Authorized Representative (please print)

Legally Authorized Representative's Relationship to Individual

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		Telepho	ne Number	
Address	City	Sta	ate	Zip Code
MEDICAL DISCLOSURE INFORMATION. In accordance with the t direction to this healthcare provider to disclose your health inform you are no longer enrolled in an applicable health plan or in receip information to last that long, please provide a different end date of You can also withdraw your consent for any or all providers you list Modifications") of this form. Place your initials next to each type of health information below th	ation to the NYIA, IPP and/ t of CBLTSS. If you do not w r event here: in Section 2 by using Section	or IRP. Thi ant your o on 3 ("Pro	s consent w consent for vider Conse	vill stay in place until sharing health ent Withdrawals/
what information you want to be disclosed next to each line below information may be disclosed (this can be different than the end da	. You can also specify an en	d date or	event for w	/hen this
Initial Below Info	rma t ion to be Disclosed			
Records from alcohol/drug treatment programs				
Clinical records from mental health programs				
HIV/AIDS-related Information			1	
Individual's or Legally Authorized Representative's Signature			Date: (MM	I/DD/YYYY)
Healthcare Provider's Name				
Medical Group/Practice Name		Telepho	ne Number	
Address	City	Sta	ate	Zip Code
MEDICAL DISCLOSURE INFORMATION. In accordance with the t direction to this healthcare provider to disclose your health inform you are no longer enrolled in an applicable health plan or in receip information to last that long, please provide a different end date of You can also withdraw your concent for any or all providers you list	ation to the NYIA, IPP and/o t of CBLTSS. If you do not w r event here:	or IRP. Thi ant your c	s consent w	vill stay in place until sharing health
You can also withdraw your consent for any or all providers you list Modifications") of this form.	In Section 2 by using Section	on 3 (Pro	vider Conse	ent withdrawais/
Place your initials next to each type of health information below th what information you want to be disclosed next to each line below information may be disclosed (this can be different than the end da	. You can also specify an en	d date or	event for w	/hen this
Initial Below Info	rma t ion to be Disclosed			
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	I/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		Telepho	ne Number	-
Address	City	Sta	ate	Zip Code
MEDICAL DISCLOSURE INFORMATION. In accordance with the t direction to this healthcare provider to disclose your health inform you are no longer enrolled in an applicable health plan or in receip information to last that long, please provide a different end date o You can also withdraw your consent for any or all providers you list	ation to the NYIA, IPP and/ t of CBLTSS. If you do not w r event here:	or IRP. Thi ant your c	s consent w	vill stay in place until sharing health
Modifications") of this form. Place your initials next to each type of health information below th what information you want to be disclosed next to each line below information may be disclosed (this can be different than the end de	y. You can also specify an er ate or event that applies to	nd date or	event for w	vhen this
Initial Below Info	rma t ion to be Disclosed			
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: (MN	I/DD/YYYY)
Healthcare Provider's Name				
Medical Group/Practice Name		Telepho	ne Number	-
Address	City	Sta	ate	Zip Code
MEDICAL DISCLOSURE INFORMATION. In accordance with the t direction to this healthcare provider to disclose your health inform you are no longer enrolled in an applicable health plan or in receip information to last that long, please provide a different end date o You can also withdraw your consent for any or all providers you list	ation to the NYIA, IPP and/ t of CBLTSS. If you do not w r event here:	or IRP. Thi ant your c	s consent w	vill stay in place until sharing health
Modifications") of this form.	, 0	,		,
Place your initials next to each type of health information below th what information you want to be disclosed next to each line below information may be disclosed (this can be different than the end d	. You can also specify an er	nd date or	event for w	vhen this
Initial Below Info	rma t ion to be Disclosed			
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: (MN	I/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	Sta	ate	Zip Code	
MEDICAL DISCLOSURE INFORMATION. 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: 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.					
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).					
Initial Below Info	tial Below Information to be Disclosed				
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	Sta	ate	Zip Code	
MEDICAL DISCLOSURE INFORMATION. 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:					
You can also withdraw your consent for any or all providers you list Modifications") of this form.	in Section 2 by using Section	on 3 ("Pro	vider Conse	ent Withdrawals/	
Place your initials next to each type of health information below th what information you want to be disclosed next to each line below information may be disclosed (this can be different than the end da	. You can also specify an en	d date or	event for w	/hen this	
Initial Below Info	rmation to be Disclosed				
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	I/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 (мм/dd/үүүү)		
Name of Provider	Signature / Date (MM/DD/YYYY)		
Name of Provider	Signature / Date (мм/dd/үүүү)		
Name of Provider	Signature / Date (MM/DD/YYYY)	<u>.</u>	
Name of Provider	Signature / Date (MM/DD/YYYY)		
Name of Provider	Signature / Date (MM/DD/YYYY)	Signature / Date (MM/DD/YYYY)	

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

Withdraw consent for <u>all</u> 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