OCFS-8001 (1/2011)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

CHILD'S NAME, (*LAST, FIRST, MI,):*		
DATE OF BIRTH:	SEX: ☐ Male ☐ Female	MEDICAID CIN #:

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, the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Federal Confidentiality law and regulations, 42 USC § 290dd-2, 42 CFR Part 2, I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and/or DRUG ABUSE TREATMENT, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* related information ONLY if I place my initials on the appropriate line in item 9(a). In the event the health information described below includes any of these types of information, AND I initial the line in Item 9(a), I specifically authorize release of such information only to the person(s) or organization(s) indicated in Item 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 redisclosing such information without my authorization unless permitted to do so under federal or state law. Any information released through this form regarding HIV-Related Information or Alcohol and/or Drug Abuse Treatment must be accompanied by a notice regarding the prohibition on redisclosure. 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 (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by submitting a written notice of my decision to revoke consent to the Individual, Entity or Health Care Provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary, and that I do not have to sign this authorization. My refusal to sign will not affect the ability to obtain treatment separate from the Bridges to Health Home & Community Based Services Medicaid Waiver Program (B2H). However, my refusal to sign this authorization may affect health information available to determine eligibility for benefits or the appropriateness or availability of services under the B2H Medicaid Waiver Program. My treatment, payment, enrollment in a health plan, or eligibility for other benefits will not be conditioned upon my authorization of this disclosure.
5. Information (except the types of information noted above in Item 2), disclosed under this authorization might be redisclosed by the recipient and this redisclosed information 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 INDIVIDUAL, ENTITY, OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

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

8. Name and complete address of person(s) or category of person, organization, facility or program to whom this information will be sent:

9 (a). Specific (minimally necessary) information to be released:

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

☐ Entire Medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referral, consults, and medical records received from other health care providers.

☐ Billing records

☐ Insurance records

☐ Other: _____

☐ Other: _____

Included: (*Indicate by Initialing*)

_____ Alcohol/Drug Abuse Treatment

_____ Mental Health Treatment Information

_____ HIV-Related Information

Authorization to Discuss Health Information

9 (b). ☐ By initialing _____ (INITIALS) I authorize _____ (NAME OF INDIVIDUAL, ENTITY OR HEALTH CARE PROVIDER) to discuss my Health Information with

_____
(INDIVIDUAL, ENTITY OR GOVERNMENTAL AGENCY NAME)

10. Reason for release of information: ☐ Participation in the B2H Medicaid Waiver Program ☐ Other:	11. Date or event on which this authorization will expire:
12. Name of person signing form in addition to the child/patient/client:	13. Relationship to/ Authority to sign on behalf of, or in addition to, child/patient/ client:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of child/patient/client:	Date:
Signature of child's parent or representative authorized by law:	Date:
Witness:	Date:
Witness Name (Print):	

** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information, which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.*

Original – Health Care Integration Agency; **Copy –** Local Department of Social Services (LDSS) or Division of Juvenile Justice and Opportunities for Youth (DJJOY), Case Planning Agency