

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.): Doe, John, Jr.		
DATE OF BIRTH: 05/19/2009	SEX: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	MEDICAID CIN #: AB12345DC

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:**
Bermuda Case Planning Agency-123 Main Street, Bronx, NY 10463

8. **Name and complete address of person(s) or category of person, organization, facility or program to whom this information will be sent:**
The name of the HCIA chosen goes HERE

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 **Included: (Indicate by Initialing)**

Insurance records _____ Alcohol/Drug Abuse Treatment

Other: _____ _____ Mental Health Treatment Information

Other: _____ _____ HIV-Related Information

Authorization to Discuss Health Information

9 (b). By initialing JD I authorize _____ to discuss my Health Information with _____

(INDIVIDUAL, ENTITY OR GOVERNMENTAL AGENCY NAME)

10. Reason for release of information: <input checked="" type="checkbox"/> Participation in the B2H Medicaid Waiver Program <input type="checkbox"/> Other:	11. Date or event on which this authorization will expire: ONE YEAR FROM TODAY
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12. Name of person signing form in addition to the child/patient/client: Janet Doe (NOT THE CHILD)	13. Relationship to/ Authority to sign on behalf of, or in addition to, child/patient/client: Mother
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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: ONLY NEEDED FOR CHILDREN OVER 18 <i>John Doe, Jr.</i>	Date: 09/01/2010
Signature of child's parent or representative authorized by law: <i>Janet Doe-MOTHER</i>	Date: 09/01/2010
Witness: Mr. Social Worker -Agency staff person	Date: 09/01/2010
Witness Name (Print): Mr. Social Worker -Agency Staff Person Signature	

* 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.