Authorization for Release of Health Information (Including Alcohol/Drug Treatment NEW YORK STATE DEPARTMENT OF HEALTH **and Mental Health Information) and Confidential HIV/AIDS-related Information**

Patient Name	Date of Birth	Patient Identification Number
Member's First and Last Name	Member's DOB	Member's CIN Number

Patient Address
Member's Known/Last Known Address

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:
"UAS NY"

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:
Lead Health Home, Care Management Agency and the Managed Care Organization (All three must be on the form)

7. Purpose for Release of Information:
HCBS Eligibility Assessment

8. Unless previously revoked by me, the specific information below may be disclosed from: Date Form is Signed (INSERT START DATE) until 18 months post start date (INSERT EXPIRATION DATE OR EVENT)

☑ All health information (written and oral), except:
Always check box above. If no exceptions write "none". If there are exceptions detail them on this line.

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☑ Records from alcohol/drug treatment programs	Box must be checked. Write in "relevant to HCBS Eligibility" in this box.	Member must Initial
☑ Clinical records from mental health programs*	Box must be checked. Write in "relevant to HCBS Eligibility" in this box.	Member must Initial
☑ HIV/AIDS-related Information	Box must be checked. Write in "relevant to HCBS Eligibility" in this box.	Member must Initial

9. If not the patient , name of person signing form:	10. Authority to sign on behalf of patient:
(If member's legal guardian/POA is signing below enter their name.)	(Name type of authority to sign for a member if applicable.)

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

Member signature (or Legal guardian/POA sign here if applicable) — SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW
Date Signed — DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

Print Staff Name and Title	Staff Signature	Date Signed
STAFF PERSON'S NAME AND TITLE	SIGNATURE	DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.