MEDICAL INFORMATION RELEASE FORM

I authorize the release of any health related information about me and any members of my family for whom I can legally give authorization, related to the provision of assistance and services and my ability to participate in work activities, including employment: by my Primary Care Provider, any other health care provider or the New York State Department of Health (SDOH) or my health plan to the New York State Office of Temporary and Disability Assistance (OTDA), the New York State Office of Children and Family Services (OCFS) or the local social services district (LDSS) as reasonably necessary for the provision of Temporary Assistance benefits, for services including child welfare services, for determining appropriate work activity assignments, for determining the need to apply and making application for Supplemental Security Income Benefits, for establishing appropriate treatment plans for restoring employability, and for determining eligibility for exemptions from the State sixty month time limit on cash assistance. If I am required to apply for benefits administered by the Social Security Administration, the information specified above may be shared with the Social Security Administration. I also agree that the information released may include HIV-related, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law, unless a box is checked below. I understand that my ability to consent to the release of information relating to any minor children for whom I may give consent is limited by the extent to which I can obtain information regarding treatment, diagnosis and procedures on their behalf.

_____ Do not disclose HIV/AIDS information _____ Do not disclose drug and alcohol information

_____ Do not disclose mental health information

I understand that I may revoke or limit this authorization at any time by notifying my local social services district in writing. However, I understand that a revocation is not effective if the provider of the information has already acted in reliance on this authorization prior to notification of its revocation. This authorization is in effect for as long as it is necessary during the time period I am receiving the Temporary Assistance benefits or services for which I am applying and until and unless I revoke or limit the authorization in writing or I sign a subsequent authorization. This authorization will end upon discontinuance of public assistance benefits.

I understand that the information provided by this authorization may be redisclosed by the recipient of this information and will no longer be protected by the Health Insurance Portability and Accountability Act as protected health information. However, the information will only be released pursuant to the New York State Social Services Law, the New York State Public Health Law and other applicable federal and state laws and regulations.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain medical treatment, payment or my eligibility for health care benefits. However, if I allege to have a medical condition that affects my ability to participate in work activities and I refuse to sign this Authorization or provide supporting medical documentation, my refusal may result in a reduction or termination of my temporary assistance benefits or non-health care related services. A copy of this authorization will be provided to you upon request.

_____ _____
Signature of Applicant or Representative Date

_____ _____
Applicant's Name (Printed) Representative's Name (Printed)

As representative for the applicant, I am authorized to act on his/her behalf because:

_____.

_____ _____
Family Member's Name Applicant's Relationship/Authority (e.g. legal guardian)

_____ _____
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