AUTHORIZATION TO RELEASE MEDICAL INFORMATION

NYC Human Resources Administration
Department of Social Services

MAP-751e (E) 06/06/2012

INFORMATION ABOUT MEDICAL OR OTHER SOURCE - PLEASE PRINT, TYPE, OR WRITE CLEARLY	
NAME AND ADRESS OF SOURCE (include Zip Code)	RELATIONSHIP TO DISABLED PERSON

INFORMATION ABOUT DISABLED PERSON - PLEASE PRINT, TYPE, OR WRITE CLEARLY		
NAME AND ADDRESS (if known) AT THE TIME DISABLED PERSON HAD CONTACT WITH SOURCE (Include Zip Code)	DATE OF BIRTH	DISABLED PERSON'S I.D. NUMBER (If known and if different than SSN.)
APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE (e.g., dates of hospital admission, treatment, discharges, etc.)		

I hereby authorize the above named source to release or disclose to the Medical Assistance Program for re-disclosure in connection with my application for public health insurance.

1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care of my impairment(s), including psychological or psychiatric impairment(s) drug abuse, alcoholism, sickle cell anemia, acquired immunodeficiency syndrome (AIDS), or test for infection with human immunodefiency virus (HIV).

2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living.

3) Information about how my impairment(s) affected my ability to do work.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end at the conclusion of any proceedings, administrative or judicial, in connection with my Medicaid application, including any appeals. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATION TO DISABLED PERSON (If other than self)	DATE
STREET ADDRESS	TELEPHONE NUMBER (include area code)	
CITY	STATE	ZIP CODE