



Medical Indemnity Fund

Re:

NYS MIF Enrollment #:

AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION

I authorize each of the parties identified below, the New York State Medical Indemnity Fund (Fund), including its authorized representatives, agents and designees, to use and disclose any and all individually identifiable medical or health information regarding my child, _____ as described below, for purposes of providing benefits and case management to him/her under the Fund. I understand that the information about my child that I authorize to be used or disclosed may be re-disclosed in accordance with the terms of this Authorization by the recipient thereof any may no longer be protected by federal or state privacy laws or regulations for the above purposes.

I specifically authorize physicians, nurses, nurse practitioners, physician assistants, occupational therapists, physical therapists, early intervention programs, psychologists, social workers, nutritionists, pharmacists, chiropractors and any other health care providers licensed or otherwise credentialed pursuant to Title VIII of the New York State Education Law (or the equivalent in another state or the District of Columbia), hospitals, schools, preschool programs, community agencies, State and/or Federal programs that have provided, provide or may provide benefits to my child, and third party payors to communicate my child's individually identifiable medical or health information by any means, including written or telephonic communications or by direct interview, regardless of whether I am present during, or notified of, such communications, and I hereby authorize Alicare Medical Management (AMM) to initiate and conduct such communications, on behalf of the Fund, whether or not I am present or have received notice thereof.

1. **What information is covered by this authorization?** This authorization applies to all medical, health, psychological, and/or psychiatric information, records and reports regarding my child's diagnoses, care and treatment.

My child's information to be disclosed may include, but is not limited to, medical or health history, chart notes, prescriptions, diagnostic test results, x-ray reports, and records received from other health care, community agencies and education providers.

2. **Who may disclose and receive information under this authorization?**

- A. Any person or facility that attends, diagnoses, treats or examines my child, including but not limited to primary and multidisciplinary health care providers, community agencies and educational entities. State and/or Federal programs that have provided, do provide or may provide benefits to my child, and third party payors. _____ (specify name, if needed), is to make this information available to AMM or any of its agents, representatives or independent contractors.
- B. AMM may re-disclose, without my further authorization, any and all of my child's individually identifiable medical or health information, whether obtained pursuant to this authorization or otherwise from any person or entity, to any of the following, (a) any person or facility that attends, treats, diagnoses or examines my child, (b) any person or facility that coordinates my child's benefits, (c) independent contractors and service providers that may require any such information for health-related purposes, (d) the Social Security Administration or a social security or vocational rehabilitation vendor and any State, Federal or local government entity when needed for health-related purposes, and (e) third party payors.



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- 3. **How long is this authorization valid?** This authorization is valid during the duration of my child’s enrollment in the NYS Medical Indemnity Fund but no later than the date upon which my child becomes 18 years of age if he or she has the capacity to make health care decisions at that time.
- 4. **Revocation of this authorization.** Unless otherwise provided by federal or state law, I understand that I may revoke this authorization at any time by notifying the Fund’s Administrator in writing, of my revocation and that my revocation shall be effective upon the Fund’s Administrator’s receipt of my notice of revocation. I also understand that my revocation of this authorization will not have any effect on any actions taken by the Fund’s Administrator before it received my revocation.
- 5. **Processing of claims.** I understand that this authorization is generally necessary for the processing of my child’s claims. I also understand that failure to sign this authorization may impair or impede the processing of my child’s claims.
- 6. **Refusal to sign.** I further understand my child’s health care providers will not condition my child’s treatment, enrollment or eligibility on my refusal to sign this authorization.

I understand that I have the right to request and receive a copy of this authorization. I understand that I have the right to inspect the disclosed information at any time. A photocopy of this authorization shall be valid and is to be accepted with the same effect as the original.

Signature of Enrollee or Enrollee’s Representative

Enrollee’s Address

Printed Name of Enrollee or Enrollee’s Representative

Representative’s Relationship to Enrollee. If Applicable

Enrollee’s Social Security Number

Date Signed

Date of Birth of Enrollee