NEW YORK STATE
DEPARTMENT of
FINANCIAL SERVICES

DFS Case #: _____

PATIENT CONSENT TO THE RELEASE OF RECORDS FOR NEW YORK STATE EXTERNAL APPEAL

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol / substance abuse treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

If the patient or the patient's designee submits this application, by signing the Patient Consent to the Release of Records for New York State External Appeal, the patient attests that the information provided in this application is true and accurate to the best of his or her knowledge.

Signature of patient is required below. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased, the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, healthcare proxy or executor, a copy of the legal supporting document should be included.

Print Name of Patient:			
Signature of Patient: (Must be signed by parent or legal guardian if patient is a minor)			
Print Name: (Of person signing form if other than the patient)			
Date: (required)			
On behalf of (if applicable):		Age: Of patient	
Patient's Health Plan ID#:			
DFS File Number (if available)			