


# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

INFORMATION ABOUT MEDICAL OR OTHER SOURCE - PLEASE PRINT, TYPE, OR WRITE CLEARLY		
Name and address of source (with zip code) David Axelrod Institute Wadsworth Center NYS Department of Health 120 New Scotland Avenue Albany, New York 12208		RELATIONSHIP TO DISABLED PERSON XHdWHANwB1
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) 1534509554	Date Of Birth 1965-11-30	DISABLED PERSON'S I.D. NUMBER (If known and if different than SSN.) B8HL2pfLws
APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE (e.g., dates of hospital admission, treatment, discharges, etc.) 8049701302		

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 immunodeficiency 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 any time. 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) TDpiVduh9K	DISABLED PERSON'S I.D. NUMBER (If known and if different than SSN.) 33OwJHUhXP	Date 2023-11-25
STREET ADDRESS 6ltB8bn6yK		TELEPHONE NUMBER 6ltB8bn6yK	
City TDLamInbWR		STATE ZHdtXS6YXF	ZIP CODE 0XirZO1jqN