



## GROUP AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This form gives permission for ACA/NY and the individuals and providers listed on this form to send, receive, and share protected health information with each other to provide continuity of care and to manage your care. Your health information is private and cannot be disclosed to anyone without your permission under Federal and New York State law. Certain individuals and entities to whom your personal health information is disclosed are also bound by these same laws, however, individuals and entities that do not provide health care may not be bound by these rules and your information may be subject to redisclosure.

### 1. Identifying Information

Member Name: Redwan Jahangir

Home Address: 29 Melrose Street Valley Stream 11580

Telephone Number: 29 Melrose Street Date of Birth: 03/18/2004

### 2. I am authorizing ACA/NY to use, send to and receive from, the entities and/or individuals listed below, my personal health information to effectively coordinate health care on my behalf.

All Waiver Providers, as listed in Section IV of the Life Plan

OPWDD

Article 16 CLinic

Dr. Towhid Shiblee

Nassau Boces Rosemary Kennedy School

Member's Name: Redwan Jahangir

Date of Birth: 03/18/2004

### 3. Term of Authorization:

Authorization will end on the earlier of \_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year) OR

Upon the following event: \_\_\_\_\_

NOTE: I understand that if I fail to specify an end date or event, the authorization will remain in effect until I revoke (cancel) it in writing or no longer receive services from ACA/NY.

### 4. Conditions of Authorization: I understand that:

- The information disclosed under this authorization by ACA/NY may be further disclosed by certain recipients and no longer protected by state and federal privacy laws.
- I have the right to revoke (cancel) this authorization at any time, and that the revocation (cancellation) must be in writing and sent to ACA/NY 300 Motor Parkway, Suite 105 Hauppauge, NY 11788.
- Any revocation (cancellation) will become effective as soon as ACA/NY receives my written notice. I understand that the revocation will not affect any uses or disclosures by ACA/NY in reliance on the authorization prior to receiving my written notice of revocation.
- I may refuse to sign this authorization. ACA/NY will not condition my enrollment in the CCO on my decision not to sign this authorization. ACA/NY may not condition payment of a claim on my decision not to sign this authorization.

### 5. Signature Required:


I have read and understood the terms of this authorization. I have also had a chance to ask questions about how my health information will be used and disclosed. By signing this authorization, I am affirming that to the best of my knowledge all information provided on this form is complete, accurate and consistent with my directions. I hereby provide my consent to the use and disclosure of my health information in the manner described above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NOTE: The signature of the individual or his or her personal representative (someone who has legal authority to act on the member's behalf) is necessary. A parent must sign for a minor dependent child.

Name of Personal Representative: \_\_\_\_\_

☒ Parent ☐ Legal Guardian\* ☐ Other \_\_\_\_\_

Signature of Personal Representative:  \_\_\_\_\_ Date: 04/17/2025  
Mohammad Tapadar (Apr 17, 2025 19:32 EDT)

\*Provide documentation supporting your legal authority to act on the Individual's behalf.

Signature:  \_\_\_\_\_  
Mohammad Tapadar (Apr 17, 2025 19:32 EDT)

Email: nymt1013@gmail.com









# ACA\_Group\_Authorization\_to\_Release\_Information (English) CURRENT

Final Audit Report

2025-04-17

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