NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Member Request for Specific Protected Medicaid Health Information

Medicaid Member Name (required): _____

Date of Birth (required): ____/____/____

At least one of the following identification numbers is required, preferably both.

Client Identification Number (CIN): _____

Social Security Number (SSN): ____ – ____ – ____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (____) ____ – ____

Dates of Records requested: From: ____/____/____ To: ____/____/____

Reason: _____

_____

_____

_____

_____

By signing this form, I understand that I am allowing the New York State Department of Health to use or disclose all of the payment information for the Medicaid Member as indicated above, including data on certain conditions such as HIV/AIDS, Mental Health and Alcohol and Substance Abuse. I specifically authorize release of such information to the Medicaid Member or the Member's parent or guardian at the address above.

_____ _____
Member Signature Date

_____ _____
If not member, name of person signing for member Authority to sign on behalf of member

_____ _____
Witness Signature Witness Name

Please return to: Medicaid Data Warehouse – CDRs
NYSDOH – MISCNY
ESP P1-11S Dock J
Albany NY 12237