NEW YORK STATE | Medical Indemnity Fund

Authorization for Release and Use of Medical Information

I authorize the New York State Medical Indemnity Fund (the Fund) and its authorized representatives, agents, contractors and designees, including Public Consulting Group, Inc. (PCG), and the parties identified below, to use and disclose any and all individually identifiable medical or health information, as described below, regarding: _____ (the Enrollee) for the express purpose of providing benefits and case management to the Enrollee under the Fund. I understand that the information about the Enrollee that I authorize to be used or disclosed may be re-disclosed in accordance with the terms of this Authorization by the recipient thereof.

I specifically authorize (i) any health care providers, including but not limited to, physicians, nurses, nurse practitioners, physician assistants, occupational therapists, physical therapists, early intervention programs, psychologists, social workers, nutritionists, pharmacists, and chiropractors, who are 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); (ii) hospitals, schools, preschool programs, community agencies, State and/or Federal programs that have provided, currently provide, or may provide benefits to the Enrollee, and (iii) third party payers, to communicate the Enrollee's individually identifiable medical or health information by any means, including written or verbal communications, regardless of whether I am present during, or notified of, such communications, and I further authorize -PCG- to initiate, participate in, 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 or health information regarding the Enrollee's diagnoses, care and treatment.

   The Enrollee's information to be disclosed may include medical or health information received from other health care providers, community agencies and education entities.

2. **Who may disclose and receive information under this authorization?** PCG may re-disclose, without my further authorization, any and all of the Enrollee's individually identifiable medical or health information to (i) any 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), (ii) hospitals, schools, preschool programs, community agencies, State and/or Federal programs that have provided, currently provide, or may provide benefits to the Enrollee, and (iii) third party payers. I further authorize PCG to re-disclose the Enrollee's individually identifiable medical or health information to other family members or parties who are able and required to provide information, such as the Enrollee's date of birth, Social Security Number, etc. as conditions of its release.

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3. **How long is this authorization valid?** This Authorization is valid during the duration of the Enrollee's enrollment in the Fund but no later than the date upon which the Enrollee 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 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 receives my revocation.

5. **Processing of claims.** I understand that this Authorization is generally necessary for the processing of the Enrollee's claims. I also understand that failure to sign this Authorization may impair or impede the processing of the Enrollee's claims.

6. **Refusal to sign.** I further understand the Enrollee's health care providers will not condition the Enrollee'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 signed Authorization. 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/Representative's Address

_____
Printed Name of Enrollee or Enrollee's Representative

_____
Representative's Relationship to Enrollee

_____
Enrollee's Social Security Number

_____
Date Signed

_____
Date of Birth of Enrollee