George E. Pataki
Governor

NEW YORK STATE
OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE
40 NORTH PEARL STREET
ALBANY, NY 12243-0001

Robert Doar
Commissioner

Informational Letter

Section 1

Transmittal:	06-INF-17
To:	Local District Commissioners
Issuing Division/Office:	Division of Employment and Transitional Supports
Date:	May 18, 2006
Subject:	LDSS-4863 MEDICAL INFORMATION RELEASE FORM
Suggested Distribution:	Employment Coordinators Temporary Assistance Directors Staff Development Coordinators
Contact Person(s):	Program Questions Welfare-To-Work Bureau: Wendy DeMarco (518) 474-1750 Drug/Alcohol related: Frances Shannon-Akstull (518) 402-3219 SSI related: Jane Wagner (518) 474-8905 Forms Questions: Bob Gullie 1-800-343-8859 Extension 6-1095
Attachments:	LDSS-4863 MEDICAL INFORMATION RELEASE FORM LDSS-4863-SP: MEDICAL INFORMATION RELEASE FORM (Spanish)
Attachment Available On – Line:	☒

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		18 NYCRR 385.2	SSL § 332-b	Welfare-To-Work Employment Policy Manual	96 INF-28

Section 2

I. Purpose

The purpose of this release is to inform social services districts about the newly developed LDSS-4863 *MEDICAL INFORMATION RELEASE FORM.*

II. Background

There are a number of situations that require districts to obtain an individual's medical information including, for example, employability determinations, determining eligibility for exemptions from the State sixty month time limit and determining the need to apply for Supplemental Security Income Benefits. In order to receive medical documentation from health care professionals, local districts must obtain an individual's authorization for the release of information. The LDSS-4863 *MEDICAL INFORMATION RELEASE FORM* has been developed to allow districts to obtain medical information from health care professionals. To obtain information from drug/alcohol treatment programs, local districts should continue to use the LDSS-4525 *CONSENT FOR DISCLOSURE OF MEDICAL AND NON-MEDICAL RECORDS FROM ALCOHOLISM AND DRUG ABUSE TREATMENT PROGRAMS.*

III. Program Implications

In order to obtain an individual's medical information, districts must have the individual's signature, or the signature of the individual's authorized representative, authorizing the health care professional to release the information. The LDSS-4863 *MEDICAL INFORMATION RELEASE FORM* authorizes health care providers to release medical information to the district when it includes an authorizing signature. If the district has obtained the individual's signed authorization, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) does not impose any additional requirements for the provider to release medical information to the district.

The LDSS-4863 *MEDICAL INFORMATION RELEASE FORM* includes provisions allowing an individual to opt out of providing information on HIV/AIDS, drug and alcohol and mental health information. An individual may refuse to disclose information related to these conditions and not lose eligibility for health care benefits. However, the district may require an individual to provide medical information consistent with Temporary Assistance and Welfare-to-Work employment requirements.

Re-disclosure Requirements

An individual's medical information may only be re-disclosed to a third party if the district has obtained the individual's signature and the re-disclosure is consistent with the purposes described in the signed authorization. Districts must exercise discretion when re-disclosing health information and information should only be re-disclosed if it is necessary and is consistent with the purposes described in the LDSS-4863 *MEDICAL INFORMATION RELEASE FORM* including determining employability and appropriate work activity assignments, establishing appropriate treatment plans for restoring employability, and determining the need to apply for Supplemental Security Income Benefits and eligibility for exemptions from the State sixty month time limit. Before re-disclosing HIV related or mental health information, it is necessary to obtain an additional authorization from the individual allowing the district to release the information to a specific provider. Districts must also comply with the applicable drug/alcohol requirements described in 96 INF-28 when re-disclosing information related to substance abuse issues. In most instances, the provider's separate authorization signed by the individual allowing it to obtain information from the district is sufficient to allow the district to release the information. Districts should retain a copy of the provider's signed authorization indicating what information was released, when, to whom and for what purpose in a secure location. When releasing HIV/AIDS information, districts must also include a statement in writing which includes the following information:

This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure.

Applicant/Recipient Requirements

An individual may be required to sign the LDSS-4863 *MEDICAL INFORMATION RELEASE FORM* (or an approved local equivalent) and provide health related information consistent with the related program requirements. For example, for employment related purposes, if an individual claims to be unable to participate in work activities because of a medical issue, or demonstrates an inability to successfully participate in work activities and a health related issue is suspected to be the cause, the individual can be required to sign the LDSS-4863 *MEDICAL INFORMATION RELEASE FORM* (or an approved local equivalent) and provide medical documentation. Failure to cooperate would result in case denial or closure until compliance. An individual's refusal to sign the authorization does not affect his/her eligibility for health care benefits, ability to obtain medical treatment or ability to obtain payment for medical treatment under any circumstances. Additionally, the related drug/alcohol requirements including when an individual may be required to sign the *LDSS-4525 CONSENT FOR DISCLOSURE OF MEDICAL AND NON-MEDICAL RECORDS FROM ALCOHOLISM AND DRUG ABUSE TREATMENT PROGRAMS* and provide information has not changed

A signed authorization is valid for as long as an individual is applying for or is in receipt of the benefits that were applicable at the time the authorization was signed, unless the individual signs a subsequent authorization or notifies the district in writing that he/she revokes the authorization.

Any questions concerning the use of the LDSS-4863 *MEDICAL INFORMATION RELEASE FORM* should be directed to the applicable program area indicated in Section 1.

IV. Forms Information

- The 11/05 versions of the LDSS-4863: *MEDICAL INFORMATION RELEASE FORM* and LDSS-4863-SP: *MEDICAL INFORMATION RELEASE FORM (Spanish)* are available for ordering. Your district **will not** automatically receive copies.

- Any requests for printed copies of the LDSS-4863 and a camera ready copy of the LDSS-4863-SP should be submitted on OTDA-876 "Request for Forms or Publications" and should be sent to:

  Office of Temporary and Disability Assistance
  BMS Document Services and Operational Support
  P.O. Box 1990
  Albany, New York 12201

  Questions concerning ordering forms should be directed to BMS Document Services at 1-800-343-8859, extension 4-9522.

- Documents may also be ordered through Outlook. To order the forms you must obtain an OTDA-876 electronically by going to the OTDA Intranet E-Forms Website at http://otda.state.nyenet/ldss_eforms/default.htm (this page contains the electronic OTDA-876.)

- For those who do not have Outlook but who have Internet access for sending and receiving email, the Internet email address is gg7359@dfa.state.ny.us. For a complete list of available forms, please refer to the OTDA Intranet E-Forms Website at http://otda.state.nyenet/ldss_eforms/default.htm.

- Local equivalents must be approved by the Office of Temporary and Disability Assistance. Any locally developed medical release forms that have not already received approval should be submitted to:

Jacqueline Brace
Office of Temporary and Disability Assistance
40 N. Pearl Street
Albany, NY 12243

Issued By_____

Name: Russell Sykes
Title: Deputy Commissioner
Division/Office: Division of Employment and Transitional Supports

MEDICAL INFORMATION RELEASE FORM

I authorize the release of any health related information about me and any members of my family for whom I can legally give authorization, related to the provision of assistance and services and my ability to participate in work activities, including employment: by my Primary Care Provider, any other health care provider or the New York State Department of Health (SDOH) or my health plan to the to the New York State Office of Temporary and Disability Assistance (OTDA), the New York State Office of Children and Family Services (OCFS) or the local social services district (LDSS) as reasonably necessary for the provision of Temporary Assistance benefits, for services including child welfare services, for determining appropriate work activity assignments, for determining the need to apply and making application for Supplemental Security Income Benefits, for establishing appropriate treatment plans for restoring employability, and for determining eligibility for exemptions from the State sixty month time limit on cash assistance. If I am required to apply for benefits administered by the Social Security Administration, the information specified above may be shared with the Social Security Administration. I also agree that the information released may include HIV-related, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law, unless a box is checked below. I understand that my ability to consent to the release of information relating to any minor children for whom I may give consent is limited by the extent to which I can obtain information regarding treatment, diagnosis and procedures on their behalf.

_____ Do not disclose HIV/AIDS information _____ Do not disclose drug and alcohol information

_____ Do not disclose mental health information

I understand that I may revoke or limit this authorization at any time by notifying my local social services district in writing. However, I understand that a revocation is not effective if the provider of the information has already acted in reliance on this authorization prior to notification of its revocation. This authorization is in effect for as long as it is necessary during the time period I am receiving the Temporary Assistance benefits or services for which I am applying and until and unless I revoke or limit the authorization in writing or I sign a subsequent authorization. This authorization will end upon discontinuance of public assistance benefits.

I understand that the information provided by this authorization may be redisclosed by the recipient of this information and will no longer be protected by the Health Insurance Portability and Accountability Act as protected health information. However, the information will only be released pursuant to the New York State Social Services Law, the New York State Public Health Law and other applicable federal and state laws and regulations.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain medical treatment, payment or my eligibility for health care benefits. However, if I allege to have a medical condition that affects my ability to participate in work activities and I refuse to sign this Authorization or provide supporting medical documentation, my refusal may result in a reduction or termination of my temporary assistance benefits or non-health care related services. A copy of this authorization will be provided to you upon request.

_____ _____

Signature of Applicant or Representative Date

_____ _____

Applicant's Name (Printed) Representative's Name (Printed)

As representative for the applicant, I am authorized to act on his/her behalf because:

_____.

_____ _____

Family Member's Name Applicant's Relationship/Authority (e.g. legal guardian)

_____ _____

Family Member's Name Applicant's Relationship/Authority (e.g. legal guardian)

FORMULARIO DE CESIÓN DE INFORMACIÓN MÉDICA

Yo autorizo la cesión de toda información referente a mi salud y a la salud de los integrantes de mi familia por quien yo tenga la capacidad legal de dar autorización, con relación a la prestación de asistencia y servicios, y mi capacidad de participar en actividades laborales, incluyendo empleos, a ser entregada por el profesional médico responsable de mi atención primaria, cualquier otro profesional médico o el Departamento de Salud del Estado de Nueva York *(State Department of Health - SDOH)* o mi plan de salud, a la Oficina de Asistencia Temporal y Asistencia para Incapacitados del Estado de Nueva York *(New York State Office of Temporary and Disability Assistance - OTDA)*, a la Oficina de Servicios para Niños y Familias del Estado de Nueva York *(New York State Office of Children and Family Services - OCFS)* o al distrito local de servicios sociales (LDSS), en tanto sea razonablemente necesario para la prestación de beneficios de Asistencia Temporal, servicios de bienestar social para niños; para seleccionar actividades laborales adecuadas; para determinar la necesidad de solicitar y presentar una solicitud de beneficios de Seguridad de Ingreso Suplementario; para establecer planes adecuados de tratamiento con objeto de restaurar la capacidad de trabajar; y para determinar si puede recibir la exención del límite estatal de sesenta meses con relación al programa de asistencia en efectivo. Si se me indica que es obligatorio solicitar beneficios suministrados por la Administración del Seguro Social, la información especificada anteriormente se puede revelar a la Administración del Seguro Social. También, estoy de acuerdo en que la información cedida incluya datos referentes a VIH, salud mental o alcoholismo y drogadicción concernientes a mí y a integrantes de mi familia, hasta donde la ley lo permita, a menos que se haya marcado uno de los casilleros a continuación. Yo entiendo que mi capacidad de autorizar la cesión de información relativa a cualquier niño menor de edad por quien yo doy mi consentimiento, está limitada por el grado hasta el cual yo pueda obtener información acerca de tratamiento, diagnóstico y procedimientos en su nombre.

_____No den a conocer información referente a VIH / Sida. _____No den a conocer información referente a drogas y alcohol.

_____No den a conocer información referente a salud mental

Yo entiendo que puedo revocar o limitar esta autorización en cualquier momento, notificándolo por escrito a mi distrito local de servicios sociales. No obstante, yo entiendo que tal revocación no entrará en efecto si quien proporciona la información ya ha actuado de acuerdo con esta autorización antes de haberse notificado su revocación. Esta autorización queda vigente por el tiempo que sea necesario en tanto yo reciba beneficios de Asistencia Temporal o servicios que yo solicite, y hasta, y a menos que yo la revoque o la limite, en cuyo caso, lo haré por escrito o firmaré una autorización subsiguiente. Esta autorización expirará cuando los beneficios de asistencia pública cesen.

Yo entiendo que la información que esta autorización cede puede ser dada a conocer nuevamente por quien la recibe, y por lo tanto, ya no estará protegida según lo estipulado por la Ley de Portabilidad y Responsabilidad del Seguro Médico *(Health Insurance Portability and Accountability Act)* en calidad de información médica protegida. No obstante, la información sólo será cedida de acuerdo con lo estipulado por la Ley de Servicios Sociales del Estado de Nueva York, la Ley de Salud Pública del Estado de Nueva York, y otras leyes y normas federales y estatales pertinentes.

Yo entiendo que puedo negarme a firmar esta autorización sin que esto afecte mi capacidad para obtener tratamiento médico, pago o acceso a beneficios de atención médica. No obstante, si yo digo tener un problema médico que afecta mi capacidad de participar en actividades laborales, y me niego a firmar esta autorización o a proporcionar documentación médica que avale mi argumento, mi negativa puede resultar en una reducción o suspensión de mis beneficios de asistencia temporal o servicios no relacionados con atención médica. De solicitarla, se le proporcionará una copia de esta autorización.

_____ _____

Firma del solicitante o representante — Fecha

_____ _____

Nombre del solicitante (en letra de imprenta) — Nombre del solicitante (en letra de imprenta)

En calidad de representante del solicitante, yo estoy autorizado para actuar en su nombre porque:

_____.

_____ _____

Nombre del familiar — Parentesco del solicitante / Autoridad (por ej., tutor legal)

_____ _____

Nombre del familiar — Parentesco del solicitante / Autoridad (por ej., tutor legal)