PATIENT CONSENT TO THE RELEASE OF RECORDS FOR NYS EXTERNAL APPEAL

The patient, the patient's designee, and the patient's provider have a right to the external appeal of certain adverse determinations made by health plans

When an external appeal is filed, a consent to release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Insurance Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring action against my health plan.

If the patient or the patient's designee submits this application, by signing the Patient Consent to Release of Records for New York State External Appeal, the patient attests that the information provided in this application is true and accurate to the best of his or her knowledge.

Signature of patient is required below. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased, the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, power of attorney, healthcare proxy, or executor, a copy of the legal supporting document should be included.

Signature:			
Print Name:			
Relationship to Patient, if applicable:			
Patient Name:		Age:	
Patient's Health Plan ID#			
Date: (required):			

OFFICE USE ONLY:

☐ Patient is unable to provide consent due to condition

☐ Patient refused to sign

____________________________ ____________________________

Hospital Staff Person's Name Date & Time