

NEW YORK STATE OFFICE FOR THE AGING

2 Empire State Plaza, Albany, NY 12223-1251

David A. Paterson, Governor

Greg Olsen, Acting Director

An Equal Opportunity Employer

PROGRAM INSTRUCTION

Number 10-PI-18

Supersedes

Expiration Date

DATE: November 22, 2010

TO: Area Agency on Aging Directors

SUBJECT: Model Applicant/Client Authorization for Release of Information

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PURPOSE: The purpose of this instruction is to provide a model authorization form to be used if the Area Agency on Aging (AAAs) want to share confidential information.

BACKGROUND: Pursuant to 45 CFR § 1321.51 information pertaining to a recipient of services is confidential. Area agencies are responsible for coordinating services provided under the Older Americans Act with other state services that benefit older adults, therefore it is expected that the AAA will share a client's information as necessary to coordinate services. The State is required to ensure that no information about an older person, or obtained from an older person by a service provider or the State or area agencies, is disclosed by the provider or agency in a form that identifies the person without the informed consent of the person or of his or her legal representative unless the disclosure is required by court order, or for program monitoring by authorized federal, State or local monitoring agencies.

Recently, an AAA asked whether there was a model form it could use to obtain an authorization from an applicant or client for the release of confidential information. The attached authorization form and instructions may be used by AAAs.

The form satisfies the federal Health Insurance Portability and Accountability Act (HIPAA) privacy requirements. However, this is not to suggest that your area agency is

a covered entity for purposes of the HIPAA privacy rules. Please consult your county attorney as to whether your agency is a covered entity for HIPAA purposes. If you would like to use the attached model form please follow your county's review and approval process for approving forms.

PROGRAMS AFFECTED:

- | | | | | |
|--------------------------------------|--------------------------------------|----------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> Title III-D | <input type="checkbox"/> Title III-E | <input type="checkbox"/> CSE | <input type="checkbox"/> SNAP | <input type="checkbox"/> Energy |
| <input type="checkbox"/> EISEP | <input type="checkbox"/> NSIP | <input type="checkbox"/> Title V | <input type="checkbox"/> HIICAP | <input type="checkbox"/> LTCOP |

Title III-B

Title III-C-1

Title III-C-2

Other: All

CONTACT PERSON: Laura Beck

TELEPHONE: (518) 408-1103

MODEL
NEW YORK STATE OFFICE FOR THE AGING
Applicant/Client Authorization for Release of Information

I, _____, currently residing at
(Name of Applicant/Client)

_____,
(Applicant/Client Address)

hereby authorize _____
(Name of Area Agency, entity or person)

to disclose the following information: _____
(Information needed)

to _____
(Name of Area Agency, entity or person)

for the following purposes: _____

I understand that this Authorization becomes effective on the date signed below and expires one year from the date of signature. **I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my eligibility for benefits or my ability to obtain services.** I further understand that the person receiving this confidential information may disclose such information which may affect the protection afforded by federal or state law.

RIGHT TO REVOKE

I understand that I have the right to revoke this Authorization at any time by sending notification in writing to the Area Agency, entity or person to whom I have granted authority to release the information. I understand that my revocation will have no effect on information that has been released under this Authorization prior to receipt of my intent to revoke such Authorization.

(Signature of Applicant/Client or Legal Representative)

(Date)

(If Legal Representative, description of relationship)

**INSTRUCTIONS FOR COMPLETION
OF
CLIENT AUTHORIZATION FOR RELEASE OF INFORMATION**

1. The Client Authorization for Release of Information is the means by which you authorize the Area Agency on Aging (hereafter referred to as “AAA”) to obtain needed information and documentation from other agencies and institutions that are in possession of records the AAA needs, in order to identify programs and services for which you may be eligible and arrange for the provision of services that will meet your needs. The Client Authorization also authorizes the AAA to release information about you in the AAA’s possession to other agencies and institutions as may be necessary to identify programs and services for which you may be eligible and to arrange for the provision of services that will meet your needs.
2. The form should be completed and signed and dated. In order to obtain a copy of the requested records or to authorize release of the information, the Legal Representative must attach all supporting legal documentation (such as a power or attorney or guardianship order) demonstrating their capacity as a Legal Representative when submitting this Authorization on behalf of the applicant/client.
3. A copy of the signed and dated form will be retained by the Area Agency on Aging in the client case file.
4. Any information that includes personal identifying information that is not covered by this authorization or for a permitted use for which an authorization is not required under HIPAA privacy rules (i.e., payment) will not be disclosed except as otherwise required by law or is necessary for purposes of program administration (i.e., payment).