CO0010

Stony Brook
Southampton Hospital
A Location of Stony Brook University Hospital
240 Meeting House Lane Southampton, NY 11968

PATIENT LABEL

General Consent and Agreements for Hospital Ambulatory Services

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 an external appeal of certain adverse determination made by health plans. In the event an external appeal is filed, consent to the 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 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 appeals 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 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 an action against my health plan.

Patient's Health Plan ID # _____

X
Signature of Patient (or representative) _____ Time _____ Date _____

I have read this entire document and I understand it.
I have been given the chance to ask questions and understand that I may ask additional questions at any time.

I also understand I may refuse to sign this form and that my health care treatment will not be affected or interrupted and payment will not be affected. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I may request a copy of this form after signing.

X _____
Signature of Patient (or representative) | Relationship (if other than patient) | Time | Date

Print Name of Witness | Title or Relationship to Patient

X _____
Signature of Witness | Time | Date