NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

AUTHORIZATION TO RELEASE HEALTH INSURANCE INFORMATION

Pursuant to Section 2559(3)(d) of NYS Public Health Law and
Section 3235-a(c) of the Insurance Law

Insured's (Child's) Name:	Date of Birth:
Parent/Legal Guardian Name:	Date of Birth:
Insurance Company Name:	Insurance Plan Name/Type:
Insurance Company Address:	Insurance Company Phone No.:
Policy Holder's Name and Address:	Policy/ID No.: Child's Member ID No.: Group No. (if applicable):
Service Coordinator Name:	Service Coordinator Agency: **Rockland County Health Department**
Service Coordinator Address: **50 Sanatorium Rd – Bldg J – Pomona, NY 10970**	Service Coordinator Phone No.: **(845)**
Municipality: **Rockland County**	Date Sent to Insurer:

I request and authorize the release of health insurance coverage information for the insured named above to my child's and family's early intervention service coordinator, provider(s), the municipality which administers the local Early Intervention Program, and the NYS Department of Health and/or its early intervention fiscal agent.

I authorize the exchange of information between these parties and the insurer named above for the purposes of facilitating claiming and assisting in the adjudication of claims for services rendered under the Early Intervention Program.

I further consent and authorized providers who submit claims to the above referenced insurer to provide such information as may be required by the insurer to facilitate claiming and payment for services rendered under the Early Intervention Program.

This request applies only to health insurance coverage under the insured's policy, plan or benefit package for the purposes of facilitating payment form the insurer for services rendered under the Early Intervention Program.

Parent/Guardian's Signature: ______________________________

Date Signed: ______________________________