Agreement with Authorized Representative for New York State of Health

IMPORTANT: As part of the application process, we may need to retrieve your confidential information from data sources, including Social Security, the Department of Homeland Security, the Department of Corrections and Community Supervision, and other state databases the Department of Health determines are necessary to decide if you qualify. We need this information to check your eligibility for coverage and to give you the best service possible. We may also check your information at a later time to make sure your information is up to date.

Account Holder Agreement to e-sign online authorization:

Does the Account Holder agree that it is their intent to sign this authorization by clicking "Account Holder Agrees" below the attestation and by electronically submitting this to NY State of Health? Do you understand that signing and submitting this authorization in this fashion is the legal equivalent of having placed your handwritten signature on the submitted authorization and this affirmation? Do you understand and agree that by electronically signing and submitting this authorization in this fashion you are affirming to the truth of the information in it?

(*Online signature*) Account Holder agrees to e-sign this authorization.

Account Holder Agreement to appoint an Authorized Representative

Does the Account Holder agree to allow this person or organization to get official information about your account and act for you on the matters you stated above? Your authorization will become effective when we receive this completed form, and it will remain effective until you or your authorized representative tells us that the authorization has ended.

(*Online signature*) Account Holder agrees.

Permanent Authorized Representative Agreement

Does the Authorized Representative agree to maintain the confidentiality of any information regarding the applicant or enrollee that NY State of Health provides? You also agree to fulfill all the responsibilities encompassed within the scope of this authorization as if you were the applicant or enrollee. You also agree to comply with applicable state and federal laws concerning conflicts of interest.

If you are agreeing on behalf of an organization, you are attesting that providers, staff members, and volunteers affirm that they will comply with applicable state and federal laws concerning conflicts of interest and confidentiality of information.

(*Online signature*) Permanent Authorized Representative agrees.