NEW YORK STATE OF OPPORTUNITY. | Office of the State Long Term Care Ombudsman

NYS Long-Term Care Ombudsman Program

AUTHORIZATION AND WAIVER of CONFIDENTIALITY

I, _____, request that the State Ombudsman and/or his local Ombudsman representative help resolve my complaint and act on my behalf.

I give the Ombudsman Program permission to reveal my identity to all parties deemed appropriate and necessary by the Ombudsman Program for the purpose of helping to resolve my complaint.

I further give Ombudsman Program representatives permission to review my records as allowed by law and to release such information as is deemed proper and necessary to the appropriate individuals or entities in order to resolve my complaint.

_____ _____

Signature of resident or resident's legal representative Date

<u>Contemporaneous Signature by Ombudsman</u>

I have been given verbal permission by _____ to work to resolve his/her complaint, to review his/her records if needed, and to reveal his/her identity in order to help resolve his/her complaint.

_____ _____

Ombudsman Date