



**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 the State Ombudsman’s 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

Contemporaneous Signature by Ombudsman

I have been given permission by,
_____, to work to resolve his/her complaint,

to review his/her records if needed, and to reveal his/her identity and/or information in order to help resolve his/her complaint.

Ombudsman

Date

The Ombudsman Program representative has my permission to access both the personal and medical records, as needed, of the above named resident.

Gregory Novack

Gregory Novack
Acting New York State Ombudsman