CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

CONSENT TO TRANSFER NECESSARY PERSONAL ASSISTANT
MEDICAL DOCUMENTATION

I, _____, consent to allow _____,
(Consumer Directed Personal Assistant Name, Print) (Old Fiscal Intermediary)

to provide a copy of my health status and immunization records identified in 18 NYCRR section 766.11(c) and (d) to _____. These records must be maintained
(New Fiscal Intermediary)

on file with the fiscal intermediary pursuant to 10 NYCRR section 505.28(i). This consent will expire one (1) year from the date of signature, below.

_____ _____
Signature Date