

County of Albany

**www.albanycounty.com**

Department of Mental Health

**Outpatient Treatment Services**

260 South Pearl Street

Albany, New York 12202

 (518) 447-4555

 Fax (518) 447-4661

Department of Mental Health

**Administrative Services**

175 Green Street

Albany, New York 12202

 (518) 447-4537

 Fax (518) 447-4577

**Behavioral Health**

**Authorization for Use and Disclosure of Protected Health Information**

|  |  |
| --- | --- |
| Patient/Recipient Name:  |       |
|  |
| DOB:  |    /   /      | Gender: [ ]  Male [ ]  Female | Last Four of SS#:  | XXX-XX-     |

I hereby authorize the use and/or disclosure of my protected health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider or health care clearinghouse, the released information may no longer be protected by federal privacy regulations, except that a recipient may be prohibited from re-disclosing substance abuse information under the federal substance abuse confidentiality requirements. State law governs the release of HIV/AIDS information and you may request a list of persons authorized to re-release HIV/AIDS related information. Release of information relating to minors may also be protected by additional state and/or federal regulations.

* Persons/Organizations providing and/or receiving the information, as noted by checking off desired selection:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Agency/ Name** | **Provide** | **Receive** |  | **Agency/ Name** | **Provide** | **Receive** |
| Albany County Department of Mental Health | [ ]  | [ ]  |  | Social Security Administration | [ ]  | [ ]  |
| Albany County Department of Social Services | [ ]  | [ ]  |  | NYS Division of Criminal Justice Services | [ ]  | [ ]  |
| Albany County District Attorney’s Office | [ ]  | [ ]  |  | NYS Department of Labor | [ ]  | [ ]  |
| Albany County Public Defender’s Office | [ ]  | [ ]  |  | NYS Office of Addiction Services & Supports | [ ]  | [ ]  |
| Albany County Department of Health | [ ]  | [ ]  |  | NYS Office for People w/ Devel Disabilities | [ ]  | [ ]  |
| Albany County Crime Victim & Sexual Violence Ctr | [ ]  | [ ]  |  | NYS Office of Mental Health | [ ]  | [ ]  |
| Albany County Sheriff’s Department | [ ]  | [ ]  |  | NYS ACCESS-VR | [ ]  | [ ]  |
|  Albany County Correctional Facility-Inmate Svcs | [ ]  | [ ]  |  | NYS Office of Children & Family Services | [ ]  | [ ]  |
| Albany County Department of Probation | [ ]  | [ ]  |  | NYS Dept of Correction & Community Supervision | [ ]  | [ ]  |
| Albany County Dept. for Children, Youth & Families | [ ]  | [ ]  |  | Homeless & Traveler’s Aid Society | [ ]  | [ ]  |
| Albany County Court | [ ]  | [ ]  |  | IPH/Interfaith Partnership for the Homeless | [ ]  | [ ]  |
| Albany County Family Court | [ ]  | [ ]  |  | Joseph’s House/ Homeless Action Committee | [ ]  | [ ]  |
| Albany Housing Authority | [ ]  | [ ]  |  | Capital City Rescue Mission | [ ]  | [ ]  |
| Albany Police Department | [ ]  | [ ]  |  | Overflow Shelter/Capital Area Council of Churches | [ ]  | [ ]  |
| Albany City Court | [ ]  | [ ]  |  | LaSalle School | [ ]  | [ ]  |
| Albany Fire Department & EMS | [ ]  | [ ]  |  | St Catherine’s Center for Children | [ ]  | [ ]  |
| Colonie Police Department | [ ]  | [ ]  |  | Peter YoungHousing*,*Industries*, &* Treatment | [ ]  | [ ]  |
| Colonie EMS | [ ]  | [ ]  |  | Capital Region BOCES | [ ]  | [ ]  |
| Guilderland Police Dept | [ ]  | [ ]  |  | The Center for Law & Justice | [ ]  | [ ]  |
| LEAD National Support Bureau | [ ]  | [ ]  |  | TASC of the Capital District, Inc. | [ ]  | [ ]  |
| Albany Medical Center Hospital | [ ]  | [ ]  |  | Reentry Opp. & Orient. Towards Success (ROOTS) | [ ]  | [ ]  |
| St. Peter’s Health Partners | [ ]  | [ ]  |  | Rehabilitation Support Services, Inc. | [ ]  | [ ]  |
| Capital District Psychiatric Center | [ ]  | [ ]  |  | Equinox, Inc. | [ ]  | [ ]  |
| Stratton VA Medical Center | [ ]  | [ ]  |  | Northern Rivers/Parsons Child and Family Center | [ ]  | [ ]  |
| Ellis Hospital | [ ]  | [ ]  |  | Depaul Community Services | [ ]  | [ ]  |
| Mohawk Ambulance Service | [ ]  | [ ]  |  | Care Design NY | [ ]  | [ ]  |
| Capital Region Health Connections | [ ]  | [ ]  |  | Lifeplan CCO | [ ]  | [ ]  |
| Monroe Plan | [ ]  | [ ]  |  | Prime Care Coordination | [ ]  | [ ]  |
| Ibero- American Action League | [ ]  | [ ]  |  | Tri-County Care | [ ]  | [ ]  |
| Whitney M. Young, Jr. Health Services, Inc | [ ]  | [ ]  |  | Capital District Center for Independence, Inc. | [ ]  | [ ]  |
| Catholic Charities | [ ]  | [ ]  |  | Independent Living Center of the Hudson Valley | [ ]  | [ ]  |
| Trinity Alliance of the Capital Region | [ ]  | [ ]  |  | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  | [ ]  |
| Alliance for Positive Health | [ ]  | [ ]  |  | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  | [ ]  |
| Unity House/Northeast Career Planning | [ ]  | [ ]  |  | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  | [ ]  |
| Bethesda House | [ ]  | [ ]  |  | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  | [ ]  |
| Capital Area Peer Services, Inc | [ ]  | [ ]  |  | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  | [ ]  |
| Mental Health Empowerment Project (MHEP) | [ ]  | [ ]  |  | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  | [ ]  |
| Albany Public Library | [ ]  | [ ]  |  | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  | [ ]  |

[ ]  All Organizations Listed Above can **provide** information

[ ]  All Organizations Listed Above can **receive** information

* Description of the information to be released (A request for the entire record must be accompanied by an explanation of why the entire record is needed):

I authorize the review and exchange of my protected health information with the agencies authorized on this form as it relates to my

treatment, effective service provision, and linkage of services.

* Purpose for release:

For all agencies authorized on this form to assist with my care coordination, treatment linkage and service provision; and for Albany

County to carry out its health oversight and legal duties as the County Mental Health Department.

The following items **must be initialed** to be included in the use and/or disclosure of other protected health information:

 HIV/AIDS related information and/or records.

 Genetic testing information and/or records.

 Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much

 and what kind of information is to be disclosed).

 **\*\*Under 42 CFR Part 2: Drug/alcohol confidentiality regulations, signature below indicates consent for**

 **use/disclosure of drug/alcohol diagnosis, treatment or referral information.**

Describe: description of information to be released as reflected above.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment, except as permitted by law.

I may inspect or copy any information to be used and/or disclosed under this authorization, as provided for in the regulations.

Unless action has been taken in reliance upon this authorization, I may revoke it at any time, provided that I do so in writing. An explanation of how to revoke this authorization may be found in Paragraph 3 of the County’s *Notice of Privacy Practices*.

**This authorization shall be valid until**  (Date or event that relates to the individual who is the subject of the Protected Health Information or the purpose of the use or disclosure, at which time this authorization to use, disclose or obtain this protected health information expires. **If left blank release will expire one year from date signed).**

Signature of Individual or Legal Representative Date

Print Individual’s Name Telephone #

Residing at Above Address

Print Name of Legal Representative (if applicable) Relationship to Recipient

Authorized Staff/Witness Signature Date

A copy of this signed form will be provided to the individual or legal guardian.

**HIV/AIDS specific information:** For questions/complaints regarding HIV/AIDS discrimination, call the New York State Division of Human Rights at (518) 474-2705 or the New York City Commission on Human Rights at (212) 306-7450.

**Federally protected substance abuse information:** I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it.

**New York State Mental Hygiene information:** I understand that my records are protected under the New York State Mental Hygiene Law section 33.13 and cannot be disclosed without my consent unless otherwise provided for in the regulations.

**Protected Health Information will not be disclosed for marketing purposes.**