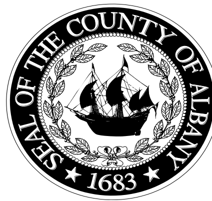

DEPARTMENT OF MENTAL HEALTH
ADMINISTRATIVE SERVICES
175 GREEN STREET
ALBANY, NEW YORK 12202
(518) 447-4537
FAX (518) 447-4577

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

Albany County Single Point of Access
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
Albany County Department of Mental Health	☐	☐
Albany County Department of Social Services	☐	☐
Albany County Central Management Unit	☐	☐
Albany Medical Center Hospital	☐	☐
Capital Region Health Connections	☐	☐
Alliance for Positive Health	☐	☐
Bethesda House of Schenectady, Inc.	☐	☐
Whitney M. Young, Jr. Health Services, Inc.	☐	☐
Mohawk Opportunities, Inc.	☐	☐
Unity House of Troy, Inc.	☐	☐
Samaritan Hospital Care Management	☐	☐
Homeless & Traveler's Aid Society	☐	☐
Equinox, Inc.	☐	☐
Rehabilitation Support Services, Inc.	☐	☐
Capital District Psychiatric Center	☐	☐
Catholic Charities	☐	☐

Agency/ Name	Provide	Receive
Northern Rivers/Parsons Child & Family Center	☐	☐
Northeast Career Planning	☐	☐
DePaul Community Services	☐	☐
St Catherine's Center for Children	☐	☐
Capital District Physicians' Health Plan, Inc.	☐	☐
St. Peter's Health Partners	☐	☐
Capital Area Peer Services, Inc.	☐	☐
Mental Health Empowerment Project (MHEP)	☐	☐
Albany County SPOA Committees	☐	☐
Other:______________________	☐	☐
Other:______________________	☐	☐
Other:______________________	☐	☐
Other:______________________	☐	☐
Other:______________________	☐	☐
Other:______________________	☐	☐
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:

Single Point of Access is a process that allows provider agencies to exchange applications for Housing, Case Management, and/or Clinical services to determine which Agency would be best suited to provide the requested services.

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 on the front of this document.

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.

ALBANY COUNTYWIDE APPLICATION FORM
ADULT MENTAL HEALTH SERVICES

This application packet must include:

- *The* ***Albany County Single Point of Access (SPOA) Release of Information;*** *on the Release of Information, list current service providers, the referring agency, medical providers, supportive family/advocates and former providers who are relevant to the referral being made.*
- *Additional attached information including copy of insurance card(s), most recent psychiatric assessment, psychosocial, lab test results, medication list, physical exam, treatment plan and any other documentation that can assist service linkage; additional information may be required dependent on type of service.*

Date of Application:	**Referent Name/Agency**
	Referent Telephone #(s)

SERVICES APPLYING FOR (*check all that apply*)			
☐ **Clinical Treatment**	☐ **Care Management**	☐ **ACT**	☐ **Peer Support**
☐ **PROS**	☐ **CTT/Aging Out Adoles.**	☐ **Residential**	☐ **Other:**

DEMOGRAPHICS		
Patient Name/Alias:	**Patient Telephone #(s):**	
Date Of Birth:		
Social Security # :	**Emergency Contact Name:**	
Address:	**Emergency Cont. Relation:**	
	Emergency Contact #:	

FINANCIAL INFORMATION			
Insurance Name(s) and Policy #s		**Income Sources/ Amounts:**	
Public Assistance:	**Current** ☐ **Yes** ☐ **No**	**Application:** ☐ **Yes** ☐ **No** **Date**	

MEDICAL HISTORY		
Primary Care Provider:	**PCP Phone #:**	**PCP Fax #:**
Other Medical Providers: (List Name/Phone /Fax)		
Allergies:		
Medical Conditions/Special Needs:		

CURRENT PROVIDERS/AGENCIES INVOLVED WITH THE PATIENT (AGENCY/NAME/TELEPHONE #):	
	Anticipated Discharge Date?
Primary Clinician:	
Psychiatrist:	
Health Home:	
Residential:	
Vocational:	
Other:	
Other:	

BEHAVIORAL HEALTH HISTORY		
Alerts (List risk factors including danger to self/others, CPL Status, assaultive behaviors, arson, legal involvement, suicide history)		
Current Psychiatric Admission ☐ **Yes** ☐ **No Admit Date Anticipated Discharge**		
Psychiatric History:		
Substance Use History:		
DSM Diagnoses:		

LEGAL HISTORY (CURRENT/PAST CONVICTIONS, INCARCERATIONS, CPS, PAROLE, PROBATION, ETC.; INCLUDE REASONS)

REASON FOR APPLYING TO PROGRAM(S) (INCLUDE PATIENT STRENGTHS, NEEDS AND GOALS; SPECIFY PER SERVICES)	
1.	4.
2.	5.
3.	6.

PLEASE STATE INDIVIDUAL'S ABILITY TO TOLERATE A GROUP STRUCTURE (FOR LIVING AND/OR CLINICAL PARTICIPATION).

DOES THE PATIENT HAVE FAMILY/OTHERS, INVOLVED IN YOUR RECOVERY?	
☐ YES ☐ NO IF YES, WHO?	
I would like more information about family support services?	☐ YES ☐ NO
I would like more information about peer support services?	☐ YES ☐ NO

PATIENT COMMENTS AND GOAL STATEMENTS	
I plan to participate in my own recovery.	☐ YES ☐ NO
I agree with the recommendations indicated in this application.	☐ YES ☐ NO
I have read and signed the Single Point of Access (SPOA) Release of Information.	☐ YES ☐ NO
I understand the SPOA Process.	☐ YES ☐ NO
The main thing I want to work on is:	

OTHER COMMENTS/CONCERNS/INFORMATION:

PATIENT SIGNATURE ______________________________ DATE ____________

REFERENT SIGNATURE ______________________________ DATE ____________