

Schenectady County Office of Community Services

797 Broadway, Suite 304

Schenectady, NY 12305

518-386-2218

Fax 518-386-2212

**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 selections:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Agency / Name** | **Provide** | **Receive** | **Agency / Name** | **Provide** | **Receive** |
| Alliance for Positive Health | [ ]  | [ ]  | Rehabilitation Support Services | [ ]  | [ ]  |
| Berkshire Farm Center | [ ]  | [ ]  | Rotterdam Police Department | [ ]  | [ ]  |
| Bethesda House of Schenectady | [ ]  | [ ]  | Safe Inc. | [ ]  | [ ]  |
| Burnt Hills-Ballston Lake Central Schools | [ ]  | [ ]  | Salvation Army’s Booth Home | [ ]  | [ ]  |
| Capital District Psychiatric Center (inpatient and/or outpatient services) | [ ]  | [ ]  | Schalmont Central School District | [ ]  | [ ]  |
| Capital Region BOCES | [ ]  | [ ]  | Schenectady City Police Department | [ ]  | [ ]  |
| Capital Regional Health Connections | [ ]  | [ ]  | Schenectady City School District | [ ]  | [ ]  |
| Captain Youth Shelter | [ ]  | [ ]  | Schenectady Co. Adult Protective Services | [ ]  | [ ]  |
| Catholic Charities | [ ]  | [ ]  | Schenectady Co. Center for Juvenile Justice | [ ]  | [ ]  |
| City Mission of Schenectady | [ ]  | [ ]  | Schenectady Co. Child Protective Services | [ ]  | [ ]  |
| Conifer Park (inpatient / outpatient) | [ ]  | [ ]  | Schenectady Co. Correctional Facility | [ ]  | [ ]  |
| Duanesburg Central School District | [ ]  | [ ]  | Schenectady Co. Department of Social Services | [ ]  | [ ]  |
| Ellis Medicine (adult & adolescent – inpatient and/or outpatient services) | [ ]  | [ ]  | Schenectady Co. District Attorney’s Office | [ ]  | [ ]  |
| Four Winds Hospital  | [ ]  | [ ]  | Schenectady Co. Family & Child Services | [ ]  | [ ]  |
| Glenville Police Department | [ ]  | [ ]  | Schenectady Co. Office of Community Services | [ ]  | [ ]  |
| Health Home Care Management Agencies | [ ]  | [ ]  | Schenectady Co. Probation | [ ]  | [ ]  |
| Hometown Health Center | [ ]  | [ ]  | Schenectady Co. Public / Conflict Defender’s Office | [ ]  | [ ]  |
| LaSalle School | [ ]  | [ ]  | Schenectady Co. Sheriff’s Department | [ ]  | [ ]  |
| Mohawk Opportunities (including ACT Team) | [ ]  | [ ]  | Schenectady Co. Youth Aide | [ ]  | [ ]  |
| Mohonasen Central School District | [ ]  | [ ]  | Schenectady Co. Youth Bureau | [ ]  | [ ]  |
| New Choices Recovery Center | [ ]  | [ ]  | Schenectady Community Action Program | [ ]  | [ ]  |
| Niskayuna Central School District | [ ]  | [ ]  | Schenectady Municipal Housing Authority | [ ]  | [ ]  |
| Niskayuna Police Department | [ ]  | [ ]  | Scotia Police Department | [ ]  | [ ]  |
| Northeast Parent & Child Society (all programs) | [ ]  | [ ]  | Scotia-Glenville Central School District | [ ]  | [ ]  |
| Northern Rivers Family Services | [ ]  | [ ]  | St. Catherine’s Center for Children | [ ]  | [ ]  |
| NYS Office of Alcoholism & Substance Abuse Services | [ ]  | [ ]  | St. Peter’s Addiction Recovery Center (inpatient and/or outpatient services) | [ ]  | [ ]  |
| NYS Office of Children & Family Services | [ ]  | [ ]  | The Monastery | [ ]  | [ ]  |
| NYS Office of Mental Health | [ ]  | [ ]  | YMCA of Greater Capital District | [ ]  | [ ]  |
| NYS Office for People w/Developmental Disabilities | [ ]  | [ ]  | YWCA of Schenectady | [ ]  | [ ]  |
| NYS Parole | [ ]  | [ ]  | Other: St. Joseph’s Addiction Treatment | [ ]  | [ ]  |
| Parsons Child & Family Center (all programs) | [ ]  | [ ]  | Other: Saratoga Hospital | [ ]  | [ ]  |

[ ]  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 linkages to services.

* Purpose of release:

For all agencies authorized on this form to assist with my care coordination, treatment linkage and service provision; and for Schenectady County to carry out its health oversight and legal duties as the County Office of Community Services.

The following items **must be initialed** to be include 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:

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 Private 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.**)

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Signature of Individual, Legal Representative or Parent/Guardian Date

 Of a minor child

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Print Individual’s Name Telephone Number (Including area code)

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**.