Form OMH 11 (3-03)

State of New York
OFFICE OF MENTAL HEALTH

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name (Last, First, M.I.) "C" No.

……

Sex……Date of Birth……

Facility Name

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information (for other than treatment, payment, or health care operations purpose), in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

Part I – Authorization To Release Information

Description of Information to be Use/Disclosed:

Telephone contact and/or written summary for the following: Universal Referral Form, Psychiatric Assessment, Psychosocial Assessment, Psychological Assessment, Physical Assessment, Treatment Plan, All relevant clinical data

Purpose or Need for Information:

1. This information is being requested:
   - ☐ by the individual or his/her personal representative; or
   - ☐ Other (please describe)_____
2. The purpose of the disclosure is: To facilitate program determination and placement

From/To: Name, Address and Title of Person/Organization/ Facility Program Disclosing Information.	To/From: Name, Address and Title of Person/Organization/Facility Program to which Disclosure is to be made.
	SPOA-Children's Services Department of Health Services Div. of Community Mental Hygiene Svcs. Bldg. C928-North County Complex P.O. Box 6100-Veteran's Memorial Hwy. Hauppauge, New York 11788 Children's SPOA Coordinator Nassau Co. Dept. of Mental Health, Mental Ret. & Devel. Disabilities 60 Charles Lindbergh Blvd. Uniondale, NY 11553

A. I Hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I Understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this Information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (insert name of facility/program) **SPOA** , shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health and Suffolk County Dept. of Health Services, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR § 164.524.

B-1. **One-Time Use/Disclosure:** I hereby permit the one-time use or disclosure of the information described above to the person/organization/facility/program identified above.

My authorization will expire:

- ☐ When acted upon;
- ☐ 90 Days from this Date;
- ☐ Other _____

B-2. **Periodic Use/Disclosure:** I hereby authorize the periodic use/disclosure of this information described above to the person/organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

- ☐ When I am no longer receiving services from (insert name of facility/program) **SPOA**
- ☐ One year from this date;
- ☐ Other _____

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Facility/Agency Name	Patient's Name (Last, First, M.I.)	"C" Wd. No.

C. **Patient Signature:** I certify that I authorize the use of my health information as set forth in this document.
I understand that I will be offered a copy of this completed form and/or that a copy will be maintained by the facility for me.

_____ _____
Signature of Patient or Personal Representative Date

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient (required if Personal Representative signs Authorization)

D. **Witness Statement/Signature:** I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY: _____
Staff person's name and title

Authorization Provided To: _____

Date: _____

To be Completed by Facility:

_____
Signature of Staff Person Using/Disclosing Information

Title _____

Date Released _____

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part 1, to the Person/Organization/Facility/Program whose name and address is:

Name:_____

Address:_____

City:_____Zip_____

I hereby refuse to authorize the use/disclosure indicated in Part 1, to the Person/Organization/Facility/Program whose name and address is:

Name:_____

Address:_____

City:_____Zip_____

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Patient's Name (Printed) Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient (required if Personal Representative signs Authorization)

I understand that I have the right to attend all meetings held to determine what services my child will receive, along with a full explanation of those services.

I understand that my input will be considered in any decisions made regarding services offered to my child and family. I understand that I am entitled to have a Parent Consultant assist me through the application review process and I will be given information about other family support services available to me.

I understand information about my child and family will be handled in a confidential manner, will be reviewed solely for the purpose of determining services, and will not be released to any other parties without my express permission.

I understand that if I disagree with what services are offered to my child, and it cannot be resolved with the SPOA Coordinator, I can appeal to the County Director of Children's Mental Health Services.

I have read and give my consent for the SPOA to review my child's application.

SPOA Services

Nassau County

In Home Programs

Children's Case Management
Intensive Case Management
Coordinated Children's Services Initiative
Home & Community Based Services Waiver
Clinical Care Consultation Team (CCCT)

Out of Home Programs

Turnabout Program (Family Based Treatment Prog.)
Teaching Family Homes Program
Lakeview House (Community Residence)
Merrick House (Community Residence)
Madonna Heights Services (RTF)
Mercy First/St. Mary's Camps (RTF)

Suffolk County

In Home Programs

Supportive Case Management
Intensive Case Management
Home Base 1 Program (CCSI)
Home & Community Based Services Waiver
Multi-Systemic Therapy Youth Team (ACT)

Out of Home Programs

CIRCLE Family Base Treatment Program
Teaching Family Homes Program
Pederson-Krag Community Residence
St. Christopher Ottilie (Community. Residence)
Madonna Heights Services (RTF)
Mercy First/St. Mary's Camps (RTF)