Onondaga County Adult SPOA
Consent for Release of Information

Client Name:_____ Gender:_____ DOB:_____

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of § 33.13 of the New York Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA) (20 USC 1232g). It is not for use for HIV-AIDS related information. Although it included many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under federal HIPPA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment of health care operations. (See 45 CFR 164.506.)

1. I hereby give permission to use and disclose health, mental health, alcohol and drug, and education records as described below.

2. The information that may be used or disclosed includes (check all that apply)

- ☐ Mental Health treatment records
- ☐ Health Records
- ☐ Alcohol/ Substance Treatment Record
- ☐ Education Records

3. This information may be disclosed between Onondaga County Adult Single Point of Access (SPOA) and partners: AccessCNY, CirCare, Helio Health, Hutching's Psychiatric Center, Liberty Resources, Loretto Community Residence, Salvation Army of Syracuse and St. Joseph's Hospital Health Care and:

- ☐ Any person or organization that possess's the information to be disclosed.

OR

_____ _____

_____ _____

4. The purposes for which this information may be used and disclosed include:

- ☐ Evaluation of eligibility to participate in program's supported by the Onondaga County Adult SPOA
- ☐ Delivery of services, including care coordination and case management;
- ☐ Payment for services; and Health Care Operations such as quality assurance.

5. I understand that New York and federal law prohibits persons that receive mental health, alcohol or substance use, and education records from re-disclosing those records without permission. I also understand that not every organizationthat may receive a record is required to follow the federal HIPPA rules governing use and disclosure of protected health information.

6. This permission expires automatically 90 days from placement in services; and/or:

- ☐ On:_____ ☐ Upon the following event:_____

7. This permission is limited as follows:

- ☐ Permission only applies to records for the dates from_____ to _____.
- ☐ Other limitation: _____.

8. I understand ths permission may be revoked at anytime by notification in writing. I understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of the possibility if I wish to revoke this permission. I also understand that records disclosed prior to this permission being revoked may not be retrieved. Any person or organization that relied on ths permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

I am the individual whose records will be used or disclosed and my permission to use and disclose my records as described.

_____ _____

Signature of Individual Date