First Name:	Middle Initial:	Last Name:	Date of Birth: mm/dd/yyyy _____/_____/_____

AUTHORIZATION FOR RELEASE OF INFORMATION

PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Purpose of Form and Uses of Information: System of Care depends on cross-system collaboration. We believe that we can provide better services for your child if systems and providers can share information. We are not able to share information unless you authorize the release of information. If you choose not to provide this authorization, System of Care may not be able to serve your child and family. We will, however, refer you to other public programs and services for which you, or your child, are eligible. You may limit the amount of time that this authorization is effective, or cancel this authorization at any time. You are entitled to receive a completed copy of this Authorization.

Notice: This release cannot be used for the release of HIV related information nor for the re-disclosure of confidential information provided to the agencies listed below except as allowable by law.

Purpose of Release: This authorization allows the noted systems and providers to share information via phone, fax or encrypted, secure electronic mail about the child/young adult named above. Information will be used to: (1) determine eligibility; (2) assess your child/young adult (3) develop a treatment plan for the child/young adult, (including wraparound services); and (4) coordinate services.

Authorized Systems and Providers: The following public systems and private providers are involved with Orange County's System of Care collaborative efforts to serve you and your family better:

- Abbott House
- ACCESS: Supports for Living
- Astor Services for Children & Families
- Children's Health Home of Upstate NY, LLC
- Children's Home of Poughkeepsie
- Cornerstone Family Health Center
- HONORehg.
- Hudson River Health Care, Inc. (dba) Community Health Care Collaborative
- Mental Health Association in Orange County
- North American Family Institute
- Orange County Departments of Mental Health, Probation, and Social Services
- Orange County Mobile Mental Health
- Rehabilitation Support Services, Inc.
- Rockland Children's Psychiatric Center
- St. Dominic's Family Services
- The Center for Human Development and Family Services

School (attending)_____and School District _____

Additional providers, family/other supports with whom intake staff may share information (e.g. Mental Health Providers, Translator/Interpreter, Primary Physician, Substance Abuse Treatment Provider, if applicable, etc.):_____

_____

_____

I, or my authorized representative, request that the following information regarding my care and treatment be released as set forth on this form and exchanged only with the agencies or individuals identified herein.

- Referral Application (includes the following Identifying Information, name, birth date, sex, race, address, telephone number)
- Intake Form (includes social history, including social services, legal history as permitted by state and federal law, hospitalization and medication history).
- Assessments (includes Mental Health Records, including treatment and service history, Psychological and/or Psychiatric Assessments and Evaluations).
- Education Records as permitted by 34 CFR Part 99.
- Medical Records from (date)_____to (date)_____. This would include entire Medical Record, including patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records and records sent to you by other health care providers.

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that information relating to **ALCOHOL and/ or DRUG ABUSE** related information may be released and exchanged with the agencies identified herein only if I place my initials on the appropriate line below:

_____Alcohol and/or Drug Abuse Treatment records as stated above and permitted by state and federal law as permitted by 42 CFR Part 2.

First Name:	Middle Initial:	Last Name:	Date of Birth: mm/dd/yyyy ____/____/_____

Terms of Authorization:

- I authorize the above systems and providers to exchange information about the child/young adult identified above for the purpose stated herein and to share information received with the agencies identified herein.
- I understand that signing or refusing to sign this consent will not affect public benefits or services for which the child or I are eligible, unless otherwise required by law.
- I understand that **this authorization will expire one year (1 yr) from the date** I or my legal representative signs this authorization **unless I limit the amount of time permitted or revoke this authorization in writing.**
- I understand that cancelling this authorization does not apply to any information already shared as a result of the original authorization.

In trying to respond to your referral in a timely manner, OCSOC partners with Orange County Mobile Mental Health team to provide wellness visits following a hospital discharge or when unable to reach you by phone. This service will be provided with respect & consideration.
I accept this policy: Yes____No_____

THIS SECTION TO BE COMPLETED ONLY BY PARENT/LEGAL GUARDIAN/REPRESENTATIVE/YOUNG ADULT:

_____ _____ _____
Printed Name of Parent/Legal Guardian/ Representative/Young Adult (if over age 18) | Signature | Date

What is your relationship to this child/young adult? _____

THIS SECTION TO BE COMPLETED ONLY BY CHILD/YOUTH:

_____ _____ _____
Printed Name: Child/Youth | Signature of Child/Youth | Date

This signature is for youth age 12 or older for release of substance abuse and/or mental health information.

THIS SECTION TO BE COMPLETED ONLY BY WITNESS:

_____ _____ _____
Printed Name of Witness | Signature of Witness | Date

DATE ON WHICH THIS AUTHORIZATION WILL EXPIRE: _____

NOTICE TO ALL AGENCIES SENDING AND/OR RECEIVING INFORMATION DISCLOSED UNDER THIS AUTHORIZATION:

1. **PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENTS IN ALCOHOL OR DRUG ABUSE TREATMENT** applies if the records released include information of any diagnosis or treatment of drug or alcohol abuse. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2).The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

2. **HIV RECORDS:** This release cannot be used for the release of HIV-related information.

3. **ALL RECORDS:** The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release is prohibited unless expressly permitted by the person to whom it pertains, by Juvenile Court/DYS in the case of youth records, or under applicable federal and/or state law.