AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA AND 42 C.F.R. PART 2

Client Name:	Date of Birth:	Social Security Number:
Client Address:		

We are committed to providing comprehensive care for your individual needs; this depends on cross-system collaboration. By signing this form you agree to the sharing of information by and between the entities listed in items 7 and 8, which are not able to share information without your authorization. You may limit the amount of time this authorization is effective or cancel this authorization at any time. You are entitled to receive a completed copy of this authorization.

Having read the above paragraph, I, or my authorized representative, by signing, request that health information regarding my care and treatment be released between and among the applicable entities as set forth on this form. I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Federal law prohibits disclosure or redisclosure of my information unless such disclosure or redisclosure is expressly permitted by my written consent or otherwise provided for by applicable regulations.

I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT (as permitted by 42 CFR Part 2), MENTAL HEALTH TREATMENT (except psychotherapy notes), and CONFIDENTIAL HIV[1] RELATED INFORMATION. If applicable, this information will only be disclosed among the entities listed if I place my initials on the appropriate line in Item 9. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9, I specifically authorize release of such information from any of the entities set forth in Item 7 to any of the entities set forth in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to any of the entities listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure, however, I acknowledge that cross system collaboration is the best practice for my care.
5. Information disclosed under this authorization may be shared among all entities listed below to the degree necessary to fulfill the reason for release of information (item 10).
6. This authorization authorizes the entities listed in Item 7to discuss my health information or medical care only with the entities listed in item 8.

7a. Treating entities authorized to release this information:	**8a. Treating entities authorized to obtain this information:**
Mental Health Clinical Provider:	Mental Health Clinical Provider:
Substance Use Disorder Outpatient Provider:	Substance Use Disorder Outpatient Provider:
Inpatient/Residential Provider:	Inpatient/Residential Provider:
Primary Care:	Primary Care:
Care Management Agency:	Care Management Agency:
Hospitals:	Hospitals:
Other:	Other:

7b. Non-treating entities authorized to release this information:		**8b. Non-treating entities authorized to obtain this information:**	
Agency/Provider	**Specific Individual**	**Agency/Provider**	**Specific Individual**
Orange County Dept. of Mental Health		Orange County Dept. of Mental Health	
Orange County Dept. of Social Services		Orange County Dept. of Social Services	
Family/ Significant Other/Other Supports		Family/ Significant Other/Other Supports:	
Developmental Disability Provider:		Developmental Disability Provider:	
Peer Services:		Peer Services:	
Legal:		Legal:	
Other:		Other:	

9. Specific information to be released:

☐ Medical Record from (insert date) to (insert date) _____

☐ Medical Record, include: ☐ patient histories, ☐ office notes **(except psychotherapy notes)**, ☐ test results, ☐ radiology studies, ☐ films, ☐ referrals, ☐ consults, ☐ billing records, ☐ insurance records.

☐ Other_____

_____

(Indicate approval by Initialing) _____

Include: **(Indicate by Initialing)**

_____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV-Related Information

_____ Primary Care Provider

10. Reason for release of information:	**11. Date or event on which this authorization will expire:**
Coordination to meet complex co-occurring needs	
12. If not the client, name of person signing form:	**13. Authority to sign on behalf of client (see instructions):**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ _____ _____ _____

Signature of client or representative authorized by law | Date | Signature of Witness | Date

State of New York

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

NOTE: This form must be attached to all disclosures/releases of information concerning substance abuse patients.

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING SUBSTANCE ABUSE PATIENT

(To accompany disclosure of information made with consent of substance abuse patient)

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2 and HIPAA). The federal rules prohibit you from making 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 and/or HIPAA. 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.

TRS-1 (5/03)

Footnotes: 1 Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

2 Item 5 does not compel an entity to release all information. Program must review applicable laws and regulations and determine the appropriate information to release based on the content of the release and the applicable laws and regulations as they apply to each specific entity. Release of information should be limited to what is necessary to fulfill the intent of the consent. Entities listed in item 7 may choose to release different information to each entity listed in item 8 in order to comply with the laws and regulations while still meeting the individual's needs. Redisclosure is not permitted without specific written consent.

Instructions:

Must include name and date of birth or Social Security number.

7a. Other

May include entities not listed in another field. May also use this field if you have more than one entity from a single category.

7b. Legal

May include probation, courts, lawyers, law enforcement agencies, etc. Must specify what entity and specific person. If either is left blank information will not be shared without an additional written consent.

7b. Other

May include entities not listed in another field. May also use this field if you have more than one entity from a single category.

9. Specific Information to be released

Individual must initial next to each line to indicate the type of information that may be released.

12. If not the client, name of person signing the form. 13 Authority to sign on behalf of client.

The individual named in item12 must have the legal authority to sign the authorization for release of health information. That legal authority must be indicated in number 13. Proof of this legal authority must accompany this release when requesting documentation (i.e. power of attorney, parent, legal guardian, etc.). Each entity must follow the laws and regulations as they pertain to them and therefore legal authority that is sufficient for one entity may not be for another which may limit the ability to share information. If the client is a minor both the parent or legal guardian and client must sign the form for OASAS licensed programs.