Authorization for the Use and/or Disclosure of Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), Family Support in Central New York, Inc. may not use or disclose your protected health information (PHI) except as permitted by state and federal laws and regulations without your prior authorization. Your signature on this form indicates you give Family Support in Central New York, Inc. permission to use and/or disclose your PHI identified below with authorized individual(s) and/or agency. Disclosure of PHI can be written, electronic, or verbal. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

SUBJECT OF PROTECTED HEALTH INFORMATION (CLIENT)

Name _____ Date of Birth _____ Telephone _____

RECIPIENT OF PROTECTED HEALTH INFORMATION

Family Support in Central New York, Inc.

Locaiton Requesting Information

☐ **155 Madison St.**
Oneida, NY 13421
Phone: (315) 941-2520
Fax (315) 531-3561

☐ **9582 Whittaker Rd**
Holland Patent, NY 13354
Phone (315) 865-4477
Fax (315) 865-4477

INDIVIDUAL / AGENCY BEING AUTHORIZED TO DISCLOSE PHI

Name of Individual / Agency _____

Address _____ City _____ State _____ Zip _____

☐ **Two Way Release** By checking this box, I authorize the individuals/agencies named in this authorization, to disclose to each other, the PHI identified below on an ongoing basis for the duration of this authorization.

DOCUMENTS AUTHORIZED FOR USE / DISCLOSURE *(Please Check All That Apply):*

- ☐ All
- ☐ SPOA/A Referral
- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluations
- ☐ CFTSS/ HCBS Referral
- ☐ Assessment Forms
- ☐ Medical History
- ☐ Emergency Dept./CPEP Records
- ☐ Psychosocial/Core History
- ☐ Educational Records / IEP
- ☐ Hospitalization History
- ☐ Medication History
- ☐ Treatment History
- ☐ Current Medications
- ☐ Crisis/Respite Referral
- ☐ Admission/Intake Information
- ☐ Discharge Summary
- ☐ Case Management History
- ☐ Current Service Plan / ISP
- ☐ Recommendations
- ☐ Other (please specify)_____

PURPOSE OR NEED FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION *(Check all that apply):*

- ☐ Access, assessment, planning, and coordination of services/treatment for your child and/or family
- ☐ Additional service/program referral
- ☐ Cross System case conference
- ☐ Other_____

Authorization for the Use and/or Disclosure of Protected Health Information

Authorization:

I have read, or had read to me, this Authorization form. I have had an opportunity to ask questions. By signing this Authorization, I am confirming that it accurately reflects my wishes regarding use and disclosure of my Protected Health Information which may include sensitive information including, but not limited to, mental health records, drug and alcohol treatment, and HIV status. I understand that records disclosed pursuant of this authorization may be re-disclosed to additional parties who are also subject to the requirements of federal law to protect this information. I understand that this authorization will automatically expire:

- ☐ One year from the date of this form
- ☐ One year, to include any future records generated after the date of signature for a period of up to one year
- ☐ This is a one-time release
- ☐ 30 days after discharge from this sequence of treatment

Signature of Client **Date**

Signature of Person Legally Authorized to Consent to Disclosure **Print Name** **Title or Relationship to Client** **Date**

Witness Signature **Print Name** **Date**

Decline Authorization:

I understand that I am under no obligation to sign this authorization. Family Support in Central New York, Inc. will not deny anyone assistance who chooses to decline authorization.

I hereby decline this authorization.

Signature Date Witness Date

Revoke Authorization:

I understand that I may revoke this authorization at any time by signing the revocation section and returning it to Family Support in Central New York, Inc. I further understand that any such revocation does not apply to the extent that persons authorized to use/disclose my health information have already acted in reliance on this authorization and I understand those records will not be retrieved.

I hereby revoke this authorization.

Signature Date Witness Date