GREENE COUNTY MENTAL HEALTH CENTER
905 Greene County Office Building
Cairo, NY 12413
Ph. 518-622-9163 Fax; 518-622-8592

PART I
AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

I, _____ _____ the undersigned, hereby consent and
(Client Name) (DOB)
authorize the Greene County Mental Health Center to exchange information with:

_____
_____
(Name, address and phone/fax number of person/organization/facility /program)

Consent to Release Information Extent or Nature of Information to be Disclosed

[ ] Presence in treatment
[ ] Diagnosis, prognosis, treatment status
[ ] Psychological/social assessments
[ ] School records
[ ] Special Education records/IEP
[ ] Treatment plans
[ ] Discharge summary
[ ] Evaluation results
[ ] Medical records
[ ] Other: _____

Purpose of Need for Information

☐To gather information to complete an assessment
☐To allow on-going communication
☐For advocacy purposes
☐To communicate with family/concerned others.
☐To provide ongoing treatment/aftercare
☐To complete an alcohol/drug evaluation
☐For coordination of treatment planning
☐ Other: _____

A. I hereby permit the use or disclosure of the above information to the person/organization/facility /program identified above. I understand that:

- Only this information may be used and/or discussed as a result of this authorization
- This information is confidential and cannot be legally disclosed without my permission.
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
- I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided by Greene County Mental Health Center. I am aware that my revocation will not be effective if the person(s) I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
- 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, nor will affect my eligibility for benefits.
- 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 regulation under 45 CFR Sec. 164.524
- I understand that any disclosure of information and/or documentation is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information and/or documentation to a party other than the one(s) designated above is forbidden without additional written authorization on my part.

B1. One Time Use and/or Disclosure: I hereby permit the one-time use or disclosure of the information described above. This authorization will expire: [ ] When acted upon [ ] 90 days from today's date_____ [ ] Upon termination from clinical services

B2. Periodic Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the above named as often as necessary to fulfill the purpose identified above. My authorization will expire:
[ ] When I am no longer receiving services [ ] One year from today's date_____ [ ] Other: _____

_____ _____
Patient's Name (printed) Signature of Patient or Parent/Guardian

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.

_____ _____
Name and Title Date

Witness

26- May-09

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PART II

REVOCATION OF AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

I, _____ _____ the undersigned,
(Client Name) (DOB)

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

_____
(Name and address of person/organization/facility /program)

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

_____
(Name and address of person/organization/facility /program)

_____ _____
Patient's Name (printed) Signature of Patient or Parent/Guardian

I have witnessed the execution of this revocation and/or refusal of authorization to disclose confidential information and state that a copy of the signed revocation/refusal of authorization to disclose confidential information was provided to the patient and/or the patient's personal representative.

_____ _____
Staff Person's Name and Title (printed) Date

_____
Staff Person's Signature

26-May-09