

Authorization for Release and Exchange of Health and Behavioral Health Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment may be released and exchanged as set forth on this form. I understand that:

1. This authorization may include disclosure of all of my health information, including where applicable, any and all information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT including CLINICAL RECORDS*, GENETIC, FAMILY PLANNING and HIV/AIDS-RELATED information. In the event the health information described below includes any of these types of information I specifically authorize release of such information to the entities indicated in Item 6.
2. With some exceptions, health information once disclosed may be redisclosed by the receiving entity. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment including Clinical Records*, Genetic, and/or Family Planning information, the receiving entity is prohibited from redisclosing such information or using the disclosed information for any purpose other than the purpose indicated by this authorization without my further authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity Releasing and Exchanging this Information:

6. Name and Address of Entities to whom this Information will be Disclosed and Exchanged:

I authorize the above listed Entity to contact the BHO Coordinator listed below to inform them of my enrollment in this treatment program and facilitate the coordination of the physical and behavioral health care services that I require. So that the quality of the services I receive may be evaluated, I also consent to all necessary communications between this facility and the following entities relative to my past alcohol and/or substance abuse treatment history; current and proposed treatment services: the New York State Department of Health; Office of Mental Health; Office of Alcoholism and Substance Abuse Services; any subsequent treatment facility or BHO Coordinator to which I may be referred; and

Behavioral Health Organization (BHO) Coordinator: _____

Managed Addiction Treatment Services (MATS) Coordinator: _____

Local Governmental Mental Hygiene Agency: _____

Other Case Manager (i.e., ACTS): _____

Other: _____

7. The Purpose of this disclosure is to allow authorized entities to communicate with each other to facilitate the coordination of my behavioral health services, integration of my physical health services and evaluation of provider performance.

8. My health information may be disclosed and exchanged for a period of three (3) years from last the date of service, or until revoked.

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:
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All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW

DATE

Witness Statement/Signature: 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 authorized representative.

STAFF PERSON'S NAME AND TITLE

SIGNATURE

DATE

This form has been approved by the NYS Department of Health, NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information.

Alcohol/drug treatment related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.