



# Office of Addiction Services and Supports

Revoked On: \_\_\_\_\_ Staff Initials: \_\_\_\_\_

## CONSENT TO RELEASE OF INFORMATION CONCERNING PROBLEM GAMBLING PATIENT LOCADTR ASSESSMENT

Patient's Last Name	First	M.I.
Case Number		
Facility		Unit

**INSTRUCTIONS:** **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

### PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

#### EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED:

All information necessary to complete a personalized Level of Care for Problem Gambling Treatment Referral "LOCADTR" assessment.

#### PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION:

I consent to the disclosure of confidential information to, and among, the New York State Office of Addiction Services and Supports (OASAS), the OASAS-Certified treatment facility identified above, and Payer/Managed Care Plan \_\_\_\_\_ of my clinical treatment including information from the OASAS Gambling Data System (GDS) and my Social Security Number.

I understand that the level of care determination assessment will only be shared with me, the OASAS treatment facility, and Payer / Plan identified above. Unless I have given written permission to share the information with other agencies, programs or payers.

I further understand that non-personal identifying information may be evaluated so that the effectiveness of the LOCADTR assessment tool can be evaluated.

I, the undersigned, have read the above and authorize the New York State Office of Addiction Services and Supports and the staff of the OASAS-certified treatment facility named above to disclose and obtain such information as herein specified.

I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164.

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Print Name of Patient)

\_\_\_\_\_  
(Print Name of Parent/Guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Date)