NEW YORK STATE
OFFICE OF ADDICTION SERVICES AND SUPPORTS

CONSENT TO RELEASE OF INFORMATION CONCERNING CHEMICAL DEPENDENCE TREATMENT FOR

PERMANENT SUPPORTIVE HOUSING

Applicant's Last Name, First, M.I.:
Housing Provider's Staff Member's Name:
Housing Provider's Name & Address:

Applicant's Medicaid Identification Number

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INSTRUCTIONS:	**1) PROVIDE A COPY OF THIS COMPLETED FORM TO THE APPLICANT;** **2) ADD A COPY OF THIS COMPLETED FORM TO THE APPLICANT'S FILE; AND**

1) I, the undersigned, Applicant, hereby **CONSENT** and authorize communication between and among the above named **Housing Provider**, New York State Office of Alcoholism and Substance Abuse Services (OASAS); New York State Department of Health (DOH); and National Center on Addiction and Substance Abuse at Columbia University (CASA).

I **CONSENT** to **DISCLOSURE OF INFORMATION** concerning my: first name; first initial of middle name; last name; maiden name; Medicaid Id number; date of birth; social security number; gender at birth, gender, date supportive housing began, date supportive housing ended, date of this consent and relevant information from the NYS Medicaid system and OASAS client data system.

Such disclosure is for the **PURPOSE** of enabling the entities listed above to communicate as to my treatment needs, activities, history and evaluate my treatment for purposes of monitoring, case management purposes, and for carrying out other official duties;

AND

2) I further **CONSENT** and authorize communication between and among the above named **Housing Provider** and the New York State Office of Alcoholism and Substance Abuse Services (**OASAS**); and OASAS to **DISCLOSE** the above referenced **INFORMATION** to National Center on Addiction and Substance Abuse at Columbia University (**CASA**), for the **PURPOSE** of Medicaid utilization analysis and program evaluation activities. I understand that any reports or studies compiled from my records disclosed pursuant to this release will not include personally identifiable information which will remain confidential and protected from further re-disclosure.

I, the undersigned, have read the above and authorize the staff of the above named disclosing entities to disclose, obtain and share such information as herein specified. I understand that, unless otherwise specified, this consent will remain in effect for five years after I sign this consent OR leave my supportive housing unit, whichever is longer, unless this consent is revoked by me.

I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations 42 CFR Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Pts. 160 &164; and that redisclosure of such information to a party other than those designated above is forbidden without additional written authorization on my part.

NOTE:	Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Chemical Dependence Treatment Patient** (TRS-1)

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, as recognized by my signature below.

______________________________ ______________________________
(Print Name of Applicant) (Signature of Applicant)

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(Date)