County of Onondaga

Department of Adult & Long Term Care Services

Aging • Mental Health • NY Connects • Protective Services for Adults • Veterans

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www.ongov.net

Joanne M. Mahoney
County Executive

Lisa D. Alford, MA
Commissioner

Onondaga County Mental Health SPOA (Adults)
2018 Permission to Use and Disclose Confidential Information

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of § 33.13 of the New York State Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA) (20 USC 1232g). It is not for use for HIV-AIDS related information. Although it includes many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under the federal HIPAA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment or health care operations. (See 45 CFR 164.506.)

1. I hereby give permission to use and disclose health, mental health, alcohol and drug, and education records as described below.
2. The person whose information may be used or disclosed is:

   Name: ________________________________ **Date of Birth:** ____________
3. The information that may be used or disclosed includes: Mental Health/Alcohol Drug/Health Treatment Records
4. This information may be disclosed by: The persons or organizations listed in **Attachment A** and/or the following persons/ organizations that provide services to me:________________________
5. This information may be disclosed to: Any person or organization that needs the information to provide service to the person who is the subject of the record, pay for those services, or engage in quality assurance or other health care operations related to that person.

   ☐ The persons or organizations listed in bold in Attachment A or ☐ the following persons or organizations: ____________________________________
6. The purposes for which this information may be used and disclosed include:
   - Evaluation of eligibility to participate in a program supported by the Onondaga County Mental Health;
   - Delivery of services, including care coordination, case management and OMH (Office of Mental Health Residential& Housing Services
   - Payment for services; and Health Care Operations such as quality assurance.

7. I understand that New York and federal law prohibits persons that receive mental health, alcohol, or drug abuse, and education records from re-disclosing those records without permission. I also understand that

not every organization that may receive a record is required to follow the federal HIPAA rules governing use and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NO OTHER PURPOSE.

8. This permission expires (check applicable box):

☐ One year from today on ________________ ☐ Upon the acceptance for services on ______________

9. I specify permission for the following time period:

☐ Permission only applies to records for the following time period: _____________ to _________

☐ Other limitation: ____

10. I understand that this permission may be revoked. I have received a Notice of Privacy Practices, and understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

I am the person whose records will be used or disclosed. I give permission to use and disclose my records as descr this document.

____ __________________

Signature **Date**

If applicant is under the age of 18 and/or has a legal guardian: I am the personal representative of the person whose records will be used or disclosed. My relationship to that person is: ____________________________.

I give permission to use and disclose my records as described in this document.

Signature____________________________ Date_____________

Print Name____