SPOA Permission Form

Onondaga County Department of Mental Health SPOA (Adults)
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 (applicant) whose information may be used or disclosed is:

   Name: _____ _____ **Date of Birth:** _____

3. The information that may be used or disclosed includes (check all that applies):
   - o Mental health treatment records
   - o Alcohol/Drug treatment records
   - o Health records
   - o Education records

4. This information may be disclosed by:
   - o Any person or organization that possesses the information to be disclosed
   - o The persons or organizations listed in Attachment A

   The following persons or 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.
   - o The persons or organizations listed in Attachment A
   - o The following persons or organizations:

   _____ _____

   _____ _____

6. The purposes for which this information may be used and disclosed include:
   - o Evaluation of eligibility to participate in a program supported by the Onondaga County Department of Mental Health;
   - o Delivery of services, including care coordination and case management;
   - o Payment for services; and Health Care Operations such as quality assurance.

Name_____

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 (fill in choice):**
   - **On** _____
   - **Upon the following event:** _____

9. This permission is limited as follows:
   - 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 described in this document.**

- _____

  Signature **Date**

For applicants under 18 or legal guardians: 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 records as described in this document.

Signature _____Date_____

Print Name_____

The SPOA Team will determine OMH Priority status and send applications to OMH Residential and housing providers.

Name_____

Attachment A
This permission to receive or disclose records containing Protected Health Information applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to residents of Onondaga County.

The SPOA Team determines OMH Priority status and sends applications to one or more of the following agencies:

AccessCNY for OMH Residential and Supportive Housing Programs
Central New York Services (CNYS) for OMH Residential and Supportive Housing Programs
Hutchings Psychiatric Center Outpatient and Residential Programs
Kalet's Adult Residence for DOH Adult Residence
Liberty Resources ESSHI Supportive Housing
Loretto Community Residences for OMH Residential Programs
Salvation Army of Syracuse for OMH Supportive Housing Programs
St. Joseph's Hospital Health Care for OMH Residential Programs
Circare for ACT, or NMCM (non-Medicaid care management), Forensic CM, or AOT Heath Home Plus CM

Agencies which send applications or collaborate with SPOA include:
ACR Health
ARISE
Auburn Community/Memorial Hospital
Bright Path Center
Catholic Charities of Onondaga County
Cayuga Counseling Services
Center for Community Alternatives (CCA)
Center for Court Innovation, Assigned Counsel
Chadwick Residence
Christopher Community
Circare
Claxton-Hepburn Medical Center
Clifton Springs
CNY OPWDD and Developmental Disabilities Regional Office
CNYPC
Conifer Park (Syracuse Outpatient Clinic)
Contact Community Services
Cortland Hospital Health Center
Crouse Hospital and 410 Crouse
Elmcrest Children's Center
Elmira Psychiatric Center
Endeavor Behavioral Health Services
Faxton-St. Luke's Hospital Health System
Greater Binghamton Health Center
(Guthrie) Cortland Medical Center
Helio Health
HHUNY (Health Homes of Upstate NY)
Hillside Children's Center
Hope Connections
Housing and Homeless Coalition of CNY (HHC) HMIS
Huntington Family Center
Hutchings Psychiatric Center
Insight House Chemical Dependency Services
Jail Ministries
Liberty Resources
McPike Addiction Treatment Center

Name_____

Mental Hygiene Legal Services
Mohawk Valley Psychiatric Center
Monroe Plan
Newark Wayne Hospital, Rochester Regional Health
North County Transitional Living Services, INC
NYS DOCCS/Parole
NYS OMH CNYPC Satellite Units Pre-Release Coordinators
NYS OMH Division of Forensics
Onondaga County Adult & LTC Services
Onondaga County Child and Family Services, ACCESS Team C&Y SPOA
Onondaga County Economic Security DSS, Jobs Plus
Onondaga County Health Department
Onondaga County Probation, Sheriff's Dept, Courts
Onondaga Nation Healing Center
Oswego Hospital Behavioral Health
Recovery Counseling, INC
Rome Behavioral Health
Salvation Army
Samaritan Center
St. Elizabeth Medical Center
St. Joseph's Hospital Health Center (SJHHC)
St. Joseph's Medical PC
Syracuse Community Health Center
Syracuse Recovery Services
Syracuse Rescue Mission Alliance
Syracuse RISE
Syracuse Veteran's Administration
The Mary Imogene Bassett Hospital
Tiny Home for Good
Toomey Residential Programs
Unity House of Cayuga County
Upstate Medical University and Community General Hospital
Vera House
Volunteer Lawyer's Project
WellPath
YMCA
YWCA

Note:
Please send, or request that treatment records be sent to the SPOA Team to complete this application!

Complete applications are triaged for quick processing.
Complete OMH high priority applications are assigned to a provider within a few days.

Name_____