

**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):

- Mental health treatment records
- Alcohol/Drug treatment records
- Health records
- Education records

4. This information may be disclosed by:

- Any person or organization that possesses the information to be disclosed
- 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.

- The persons or organizations listed in Attachment A
- 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 Department of Mental Health;
- Delivery of services, including care coordination and case management;
- 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 Health 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.

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**Name** \_\_\_\_\_