

**AUTHORIZATION FOR  
RELEASE OF INFORMATION**

Patient's Name (Last, First, MI)

.....  
Sex ..... Date of Birth .....

Facility Name

**Ontario County Mental Health Center**

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person. A separate authorization is required to use or disclose confidential HIV related information.

**Part 1: Authorization to Release Information**

**Description of Information to be Used/Disclosed:**

Mental health records or communication pertinent to urgent/safety issues and/or emergency/crisis situation.

**Purpose or Need for Information:**

1. This information is being requested:

- By the individual or his/her personal representative; or
- Other (please describe): Ontario County Mental Health Center

2. The purpose of the disclosure is (please describe):

Emergency contact for urgent/safety issues and/or emergency/crisis situations, and/or when OCMHC is unable to reach or contact the above-named individual and there is likelihood or concern about possible safety risk.

To/From: Name, Address & Title of Person/ Organization/  
Facility/Program Disclosing Information

To/From: Name, Address & Title of Person/Organization/Facility/  
Program to Which this Disclosure is Made.

*NOTE: If the same information is to be disclosed to multiple parties for the same period of time, this authorization will apply to all parties listed here.*

**Ontario County Mental Health Center (OCMHC)  
3019 County Complex Drive  
Canandaigua, New York 14424  
(585) 396-4363 (clinic)  
(585) 396-4993 (fax)**

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:

1. Only the information described in this form may be used and/or disclosed as a result of this authorization.
2. This information is confidential and is protected under federal privacy regulations (HIPAA and 42 CFR Part 2- substance abuse treatment) and the NYS Mental Hygiene Law and cannot legally be disclosed without my permission.
3. NOTICE OF DISCLOSURE: Further disclosure by the recipient of any information obtained pursuant to this authorization is prohibited unless written permission for such disclosure is obtained from the person to whom it pertains. Substance abuse treatment records, individually identifiable health information and mental health records are protected by Federal confidentiality rules (42 CFR Part 2 and 45 CFR Part 164 - HIPAA) and New York State Mental Hygiene Law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate any alcohol or drug abuse patient.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by the Ontario County Mental Health Center.  
I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524 and NYS Mental Hygiene Law §33.16).

**B-1 One-Time Use/Disclosure:** I hereby permit the one-time use or disclosure of the information described above to the person/organization/facility/program identified above.

My authorization will expire:

- When acted upon;
- 90 Days from this Date
- Other \_\_\_\_\_

