AUTHORIZATION FOR RELEASE OF INORMATION

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 including diagnoses, treatment recommendations, medications, and any other pertinent information relevant to your treatment at this clinic

Purpose or Need for Information:

1. This information is being requested:
   - ❑ By the individual or his/her personal representative; or
   - X Other (please describe): **Ontario County Mental Health Center**
2. The purpose of the disclosure is (please describe):

Ongoing collaboration or coordination, continuity of care, and/or outreach support services

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.
Kim Hay, Lakeview Care Manager **Lakeview Health Services, Inc.** **3019 County Complex Drive** **Canandaigua, New York 14424** **(585) 396-4363 (clinic)** **(585) 396-4993 (fax)**	***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** **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 _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Agency Name	Patient's Name (Last, First, MI)	
Ontario County Mental Health Center		

B-2. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/ organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

- ❑ When I am no longer receiving services from Ontario County Mental Health Center;
- ❑ One year from this date;
- X Other: 30 days after I am no longer receiving services from Ontario County Mental Health Center

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

Is patient a minor? ☐ Yes ☐ No Under age 12? Yes No Is adult patient legally reponsible for their own care? Yes No

Patient's Signature
(required for patients 12 years and older)

Personal Representative's Signature
(required for minors)

Patient's Name (Printed)

Personal Representative's Name (Printed)

Description of Personal Representative's Authority to Act for the Patient
(Required if Personal Representative Signs Authorization.)

Date

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was offered to the patient and/or the patient's personal representative.

WITNESSED BY:

Staff Person's Name and Title

Authorization Provided to:

Date:

To be Completed by Facility:

Signature of Staff Person Using/Disclosing Information

Title

Date Released

Part 2: Revocation of Authorization to Obtain and/or Release Information

I hereby revoke my authorization to use/disclose information indicated in Part 1, to the Person/Organization/Facility/Program whose name and address is:

I hereby refuse to authorize the use/disclosure indicated in Part 1, to the Person/Organization/Facility/Program whose name and address is:

Is patient a minor? ☐ Yes ☐ No Under age 12? Yes No Is adult patient legally reponsible for their own care? Yes No

Patient's Signature
(required for patients 12 years and older)

Personal Representative's Signature
(required for minors)

Patient's Name (Printed)

Personal Representative's Name (Printed)

Description of Personal Representative's Authority to Act for the Patient
(Required if Personal Representative Signs Revocation of Authorization.)

Date