CLIENT CONSENT INSTRUCTION SHEET FOR STAFF
Scenario: Permission for Coordinated Case Management (CDPHP Nurse can talk to Agency Case Manager)

Authorization to Release Health Information

Section 1

Fill In →

Name Client Name ID # ID# If Known DOB XX / XX / XXXX (MM/DD/YYYY)

By completing this form you are authorizing Capital District Physicians' Health Plan, Inc. and its affiliates (hereafter referred to as "CDPHP®") to disclose your information to the individual or entity identified by you below.

Section 2—I authorize the use or disclosure of the health care information as described below.
You must check box 1 or 2. Box 3 is optional.

Check Box #1 →

☑ 1. All information available in my CDPHP records. This includes information relating to:

- Alcohol and/or Substance Abuse* *(see pg. 2 of this form)*
- Mental Health Conditions
- HIV/AIDS** *(see pg. 2 of this form)*
- Genetic Diseases or Tests
- Family Planning, including Abortion
- Sexually Transmitted Diseases

☐ 2. All information included above *except* _____

_____

Check Box #3 →

☑ 3. Allow the individuals or entities listed below to make changes to my address, phone number, and/or primary care physician (PCP).

Section 3—*This information may be disclosed to the following individuals or entities:*

Name: Agency Case Manager Name

Phone Number: please list phone #

Name: _____

Phone Number: _____

Section 4—*Check only one box for the period of time the authorization is to be in effect:*

Check Box →

☑ duration of enrollment with CDPHP *or*

☐ start date (MM/DD/YYYY) ___ /___ /_____ to end date (MM/DD/YYYY) ___ /___ /_____

In the case of minor dependent, this authorization will terminate upon the first of the following to occur: written revocation by the undersigned, the expiration date of the time period noted above, or when the named minor dependent reaches the age of eighteen (18) years.

Check Box →

Section 5—The reason I am authorizing the release of information is:

☑ My request *or* ☐ Other *(please describe)*: _____

Section 6—Sign and Date This Form

Client Signs & Dates →

Client Signature
Signature

Client Name
Print Name

XX / XX / XXXX
Date of Signature (MM/DD/YYYY)

Self
Relationship to Member

Options to Get Consent to CARES, Inc.

1. Upload to HMIS
2. Scan and Send to skreis@caresny.org
3. Faxed to CARES at 489.2237 Attn: Stephanie Ford Kreis