THE ST PAUL'S CENTER, INC. AUTHORIZATION/CONSENT FOR RELEASE OF INFORMATION

Recipient Name: Date of Birth:

I hereby authorize the use or disclosure of my individual identifiable protected health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider or clearinghouse, the released information may no longer be protected by federal privacy regulations, except that a recipient may be prohibited from redisclosing chemical dependency and mental health information under the state and federal privacy and confidentiality requirements, and applicable law.

***Person/Organization providing the information:** ***Person/Organization receiving the information**

***Mental Health Records:** Yes ***Chemical Dependency Records:** Yes ***Medical Records:** Yes

*** Education Records** Yes

***Dates of Information to be released:** FROM: TO:

***Description of Information to be released: (check all applicable)**

☒ Admission Note	☒ Psychosocial Assessment	☒ Psychiatric Evaluation
☒ Medication Review/Records	☒ Progress Note	☐ Treatment Plan – Goals Plans
☒ Discharge Summary	☐ Progress Toward Txt Goals	☐ Service Plan
☒ Financial Information	☐ Case Summaries	☐ Presence in Treatment
☐ Psychological Test/Assessment	☐ Selected Case Notes	☒ Medical Records
☒ Other: Current circumstances of shelter stay		

***Purpose for this disclose is: (check all applicable)**

☒ Coordination of Treatment	☐ Legal Issues	☒ Medical Issues
☐ Previous Provider of Services	☐ Referral Out	☒ Contact Referral Source
☒ Collateral Requirements	☐ Verify Attendance	
☒ Other: Current circumstances of shelter stay		

I understand that my health care and the payments for my health care will not be affected if I do not sign this form, except in some situations when information is needed for payment, enrollment, referral, etc.

I understand that I may revoke this consent at any time except to the extent that action has been taken on it I understand that my records are protected under the state and federal regulation governing privacy and confidentiality, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in regulation or required by law.

***This authorization/consent expires on:**

☐ Specify Date: ☐ Upon Release of Specified Info. ☐ 60 Days After Termination of Treatment

Other Conditions:

_____	_____	_____
***Signature of recipient or legal rep.**	***Print Name of Recipient or legal rep.**	***Date**

Legal representative relationship to recipient:

_____	_____	_____
***Signature of witness/parent**	***Print name of witness**	***Date**

Release of HIV/AIDS information must be done on a separate specialized NYS Department of Health authorization/consent form

All *and Bolded areas MUST be filled in.

CANCELLATION/REFUSAL TO RELEASE INFORMATION

I HEREBY CANCEL OR REFUSE TO AUTHORIZE THE RELEASE OF INFORMATION INDICATED ABOVE.

_____	_____	_____	_____
***Signature of recipient or legal rep.** Date: _____	*** Relationship**	*** Signature of witness** Date: _____	***Title**