DEPARTMENT OF MENTAL HEALTH
**ADMINISTRATIVE SERVICES**
175 GREEN STREET
ALBANY, NEW YORK 12202
(518) 447-4537
FAX (518) 447-4577

COUNTY OF ALBANY
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DEPARTMENT OF MENTAL HEALTH
**OUTPATIENT TREATMENT SERVICES**
260 SOUTH PEARL STREET
ALBANY, NEW YORK 12202
(518) 447-4555
FAX (518) 447-4661

## Albany County Single Point of Access
## Authorization for Use and Disclosure of Protected Health Information

Patient/Recipient Name: _____

DOB: ___/___/_____ Gender: ☐ Male ☐ Female Last Four of SS#: XXX-XX-_____

I hereby authorize the use and/or disclosure of my 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 health care clearinghouse, the released information may no longer be protected by federal privacy regulations, except that a recipient may be prohibited from re-disclosing substance abuse information under the federal substance abuse confidentiality requirements. State law governs the release of HIV/AIDS information and you may request a list of persons authorized to re-release HIV/AIDS related information. Release of information relating to minors may also be protected by additional state and/or federal regulations.

■ Persons/Organizations **providing and/or receiving** the information, as noted by checking off desired selection:

| Agency/ Name | Provide | Receive |
|---|---|---|
| Albany County Department of Mental Health | ☐ | ☐ |
| Albany County Department of Social Services | ☐ | ☐ |
| Albany County Central Management Unit | ☐ | ☐ |
| Albany Medical Center Hospital | ☐ | ☐ |
| Capital Region Health Connections | ☐ | ☐ |
| Alliance for Positive Health | ☐ | ☐ |
| Belvedere Health Services | ☐ | ☐ |
| Whitney M. Young, Jr. Health Services, Inc. | ☐ | ☐ |
| Catholic Charities | ☐ | ☐ |
| Capital Area Peer Services, Inc. | ☐ | ☐ |
| Mental Health Empowerment Project (MHEP) | ☐ | ☐ |
| Homeless & Traveler's Aid Society | ☐ | ☐ |
| Equinox, Inc. | ☐ | ☐ |
| Rehabilitation Support Services, Inc. | ☐ | ☐ |

| Agency/ Name | Provide | Receive |
|---|---|---|
| Parsons Child and Family Center | ☐ | ☐ |
| Northeast Career Planning | ☐ | ☐ |
| Capital District Psychiatric Center | ☐ | ☐ |
| Capital District Psychiatric Center-Family Support | ☐ | ☐ |
| Other:_____ | ☐ | ☐ |
| Other:_____ | ☐ | ☐ |
| Other:_____ | ☐ | ☐ |
| Other:_____ | ☐ | ☐ |
| Other:_____ | ☐ | ☐ |
| Other:_____ | ☐ | ☐ |
| Other:_____ | ☐ | ☐ |
| Other:_____ | ☐ | ☐ |
| Other:_____ | ☐ | ☐ |
| Other:_____ | ☐ | ☐ |

☐ All Organizations Listed Above can **provide** information

☐ All Organizations Listed Above can **receive** information

■ Description of the information to be released (A request for the entire record must be accompanied by an explanation of why the entire record is needed):

I authorize the review and exchange of my protected health information with the agencies authorized on this form as it relates to my treatment, effective service provision, and linkage of services.

■ Purpose for release:

Single Point of Access is a process that allows provider agencies to review and exchange applications for Housing, Case Management, and/or Clinical Services in specific meetings to determine which agency would be best suited to provide the requested services. Confidentiality is contained within these meetings

The following items **must be initialed** to be included in the use and/or disclosure of other protected health information:

_____ HIV/AIDS related information and/or records.
_____ Genetic testing information and/or records.
_____ Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed).
****Under 42 CFR Part 2: Drug/alcohol confidentiality regulations, signature below indicates consent for use/disclosure of drug/alcohol diagnosis, treatment or referral information.**

Describe: description of information to be released as reflected on the front of this document.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment, except as permitted by law.

I may inspect or copy any information to be used and/or disclosed under this authorization, as provided for in the regulations.

Unless action has been taken in reliance upon this authorization, I may revoke it at any time, provided that I do so in writing. An explanation of how to revoke this authorization may be found in Paragraph 3 of the County's *Notice of Privacy Practices.*

**This authorization shall be valid until** _____ (Date or event that relates to the individual who is the subject of the Protected Health Information or the purpose of the use or disclosure, at which time this authorization to use, disclose or obtain this protected health information expires. **If left blank release will expire one year from date signed).**

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Signature of Individual or Legal Representative — Date

Print Individual's Name — Telephone #

Residing at Above Address

Print Name of Legal Representative (if applicable) — Relationship to Recipient

Authorized Staff/Witness Signature — Date

A copy of this signed form will be provided to the individual or legal guardian.

**HIV/AIDS specific information:** For questions/complaints regarding HIV/AIDS discrimination, call the New York State Division of Human Rights at (518) 474-2705 or the New York City Commission on Human Rights at (212) 306-7450.

**Federally protected substance abuse information:** I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it.

**New York State Mental Hygiene information:** I understand that my records are protected under the New York State Mental Hygiene Law section 33.13 and cannot be disclosed without my consent unless otherwise provided for in the regulations.

**Protected Health Information will not be disclosed for marketing purposes.**