The Homeless and Traveler's Aid Society of the Capital District, Inc. (HATAS)

Authorization for Use and Disclosure

I, _____, hereby authorize the use and/or disclosure of my protected health information as described below. I understand that this authorization is voluntary and may be revoked at any time, in writing, except whereas action has been taken in reliance upon it. I understand that such disclosure is routine and may be necessary for the service(s) I have requested. I understand that the information authorized for disclosure may be received by agencies other than those governed by federal privacy regulations regarding substance abuse information, but will be prohibited from redisclosing substance abuse under Federal Confidentiality Regulations protecting such information. I have the right to obtain or inspect the information being used or disclosed under this authorization.

The Homeless and Traveler's Aid Society is authorized to disclose to, and obtain information from:

Disclose To	Obtain From		Disclose To	Obtain From	
☐	☐	Albany County Department of Mental Health, Albany	☐	☐	Mercy House, Albany
☐	☐	Albany County Dept. of Social Services, Albany	☐	☐	National Grid, Syracuse
☐	☐	Albany County Department of Probation, Albany	☐	☐	NY State Parole
☐	☐	Albany Housing Authority, Albany	☐	☐	Rehabilitation Support Services, Albany
☐	☐	Albany Medical Center, Albany	☐	☐	Schuyler Inn, Menands
☐	☐	Booth Home (Salvation Army), Schenectady	☐	☐	Social Security Administration, Albany
☐	☐	Capital City Rescue Mission, Albany	☐	☐	St. Charles Lwanga Center, Albany
☐	☐	Capital District Psychiatric Center, Albany	☐	☐	St. Peter's Addiction Recovery Center (SPARC), Albany
☐	☐	Clearview Center, Albany	☐	☐	United Tenants of Albany, Albany
☐	☐	Equinox, Albany	☐	☐	Soldier On, Albany Housing Coalition, Albany County Veterans Bureau
☐	☐	Interfaith Partnership for the Homeless, Albany	☐	☐	Veterans Administration
☐	☐	Legal Aid Society of Northeastern New York, Albany	☐	☐	Red Cross
☐	☐	Marillac, Albany	☐	☐	

I hereby consent to the release of the following information: (check and initial all that apply).

- ☐ Intake and assessment information _____
- ☐ Treatment and Service plans _____
- ☐ Discharge summary _____
- ☐ Verbal Exchange of Information _____
- ☐ Psychosocial assessment _____
- ☐ Court Related Information _____
- ☐ Medical Records _____
- ☐ Medications _____
- ☐ Diagnosis _____
- ☐ Other: (specify) _____ _____
- ☐ Substance Abuse Treatment Information (Specify what and how much): _____ _____

  For the purpose of: _____
- ☐ Limitations or comments (optional): _____

_____

_____

This authorization expires 12 (twelve) months from its signing or upon withdrawal from the program unless an alternate condition is specified below. I understand that information pertaining to drug and alcohol abuse patients is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of such records. I also understand that my records may be protected under the New York State Mental Hygiene Law Section 33.13. This consent may be revoked, in writing, at any time, except whereas action has been taken in reliance on it.*

** Time period, condition, or event replacing period specified above:* _____

Consumer Signature	Date	HATAS Personnel Signature	Date
		HATAS Personnel (print name)	