County Executive

Theresa A. Beaudoin
Commissioner

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Child's Name: _____

Date of Birth: _____ Child's DOB: _____

I hereby authorize the use or disclosure of my individually identifiable 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 re-disclosing substance abuse information under the federal substance abuse confidentiality requirements. State law governs the release of HIV information and you may request a list of persons authorized to re-release such information. The information exchanged may be verbal or written.

Persons/organizations providing the information:	**Persons/organizations receiving the information:**
_____	_____
_____	_____
_____	_____

1. Description of information including date(s): _____

_____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my initials in the applicable space next to the type of information.

___ HIV/AIDS information ___ Mental health information ___ Drug/alcohol diagnosis, treatment, or referral information

2. Purpose of the use/disclosure: _____

3. The person/program requesting the authorization will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

4. 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, etc.

5. I understand that I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it.

6. I may remove this authorization at any time by notifying the Rensselaer County Dept. of Social Services in writing, but if I do it will not have any effect on any actions they took before they received the revocation.
This authorization will expire in one year unless I specify the date, event, or condition which it will expire below:

_____

HIV specific information:
For questions/complaints regarding HIV 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 without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Signature of Patient or legal representative: _____ Date: ___/___/___

Printed Name of patient's legal representative: _____ Relationship: _____

Witness: _____ _____
(Print Name) (Signature)

DSS-632 (Rev. 3/86)

CONSENT FOR VERIFICATION OF INFORMATION

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

NAME OF APPLICANT OR RECIPIENT	SOCIAL SERVICES DISTRICT	DATE

I, the undersigned, hereby give my consent to the above identified Department of Social Services to verify information relating to my eligibility for public assistance and care, food stamps and other benefits under the Social Services Law, as follows:

Yo, el abajo firmante, por este medio doy mi consentimiento al Departamento de Servicios Sociales identificado arriba para que verifique información relacionada a mi elegibilidad para la Asistencia Pública y cuidado, cupones de alimentos y otros beneficios bajo la Ley de Servicios Sociales de la manera siguiente:

NAMES OF SPECIFIC SOURCES FOR CONTACT NOMBRES DE FUENTES ESPECIFICAS PARA COMUNICARSE

X _____ _____

Signature of Applicant or Recipient
Firma del Solicitante o Beneficiario

Date
Fecha

If signed with an X a witness other than the caseworker or Department representative should be obtained.

X _____ _____

Signature of Witness
Firma del Testigo

Date
Fecha

X _____

Signature of Caseworker or Department Representative