NYC Children's Single Point of Access:
Authorization To Release Information

Child's/Patient's Name:	**Date of Birth:**

I, _____, authorize the NYC Department of Health and Mental Hygiene, through its Children's Single Point of Access (CSPOA), to both release and receive or gain access to the following information about my child (or about me if I am age 18 years or older):

All educational, medical, substance abuse treatment, and mental health assessments, including the Universal Referral Form; psychiatric and psychological evaluations; psychosocial assessments; discharge reports; all clinical data; psychotherapy notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation(s) during a private counseling session or a group, joint, or family counseling session, which may be separated from the rest of my medical records; all data possessed or obtained by CSPOA; and other information listed in the box below:

Other information to be released [if the information released is subject to 42 CFR Part 2, list the exact information here]:

I authorize CSPOA to release to and receive or gain access to the information listed above from any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider, social worker, social service organization, mental health service provider, or additional person(s) or organization(s) listed in the box below that has provided or will provide payment, treatment, or services to my child or on my child's behalf (or to me or on my behalf if I am age 18 years or older):

Name of other person(s) or organization(s) to release information [if the information released is subject to 42 CFR Part 2, list the exact person(s) or organization(s) and name of contact(s) that will receive the information]:

This authorization will expire when revoked by me unless a date or event is specified in the box below:

Date or event on which this authorization will expire:

This information is released or received by CSPOA at my request and/or for the purposes of evaluation for services, eligibility determination, referral to services, or provision of services for my child (or me if I am age 18 years or older), and/or for the purpose(s) listed in the box below:

Other purpose(s) of release:

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my child's ability (or my ability if I am age 18 years or older) to obtain treatment, nor will it affect my child's eligibility for services (or my eligibility if I am age 18 years or older). With some exceptions, information once released may be rereleased by the recipient.

I further understand that I have the right to revoke this authorization at any time by writing to: DOHMH, Attn: CSPOA, 42-09 28th St., Long Island City, NY 11101. I am aware that my revocation will not be effective if the persons or organizations I have authorized to use and/or disclose information pertaining to my child (or me if I am age 18 years or older) have already taken action because of my authorization.

_____ _____

Signature of the patient or representative authorized by law Date

3.25