New York City (NYC) Children's Single Point of Access

AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization must be completed by the patient (child) or their personal representative, if the child is a minor, to consent to the release/use/disclosure of patient's information relating to health, mental health treatment and substance abuse treatment, in accordance with State and Federal laws and regulations. A separate authorization is required to use or disclose confidential HIV-related information.

This authorization permits the use, disclosure, and re-disclosure of health, substance abuse treatment information and mental health information for the purposes of planning, care coordination, and delivery of services for the child referred for intensive mental health services.

Person whose information may be used or disclosed:

Child's Name:_____ Date of Birth:_____
(referred in this document as "my child" or "your child")

PART 1: Authorization to Release Information

Description of Information to Be Used/Disclosed:

The Universal Referral Form, educational, medical, substance abuse treatment and mental health assessments, including: psychiatric and psychological evaluations, psycho-social assessments, discharge reports, all relevant clinical data, and other:
_____.

Purpose or Need for Information: Your child has been referred for intensive mental health services. New York City Department of Health and Mental Hygiene under its NYC Children's Single Point of Access program (CSPOA) conducts eligibility determination and care coordination activities for children in need of intensive mental health services. A CSPOA specialist from New York City Health Department must review information from the Universal Referral Form so that the right services may be provided to your child.

Name of person/organization/facility/program to which New York City Department of Health and Mental Hygiene/NYC's Children Single Point of Access program will disclose your child's information to:

To conduct eligibility determination and care coordination activities for your child a CSPOA specialist will need:

- To contact you, in addition to the referral source, including the writers of the evaluations to discuss treatment for your child; and
- To share, re-release, the information described above with a variety of agencies and organizations that are contracted through the New York State Office of Mental Health, the New York City Department of Health and Mental Hygiene, State Department of Health, and/or Health Homes Servicing Children to make recommendations for the appropriate program for possible enrollment for intensive mental health services. The agencies and organizations that may receive your child's information include the following: Home and Community Based Services (HCBS) waiver providers, Care Management Agencies, Non-Medicaid Care Coordination Providers, Health Homes Serving Children and Community Residences. In addition, you understand that referrals may be discussed with and provided to the following agencies/programs: Office of Persons with Developmental Disabilities, the Family Resource Center, Intensive Crisis Stabilization and Treatment, Home Based Crisis Intervention, Functional Family Therapy (FFT), the New York State Office of Children & Family Services, the Local Department of Social Services, and the Pre-Admission Certified Committee.
- On this authorization form, you are being asked to consent to have your child's psychiatric and psychosocial evaluation, substance abuse treatment information, and medical and mental health information released by your referral source to New York City Health Department; and you are being asked to consent to have New York City Health Department re-release the information described above to organizations that will be assigned to provide your child with services. I understand that I have the right to cancel my permission to release the information or withdraw from the referral process at any time by contacting the New York City CSPOA Administrative Office at 347-396-7205.

Purpose or Need for Information:

1. This information is being requested:
   - ☐ By the individual or their personal representative; or
   - ☐ Other (please describe) _____
2. The purpose of the disclosure is (please describe): to facilitate program determination and placement.

It is understood that this information will be used to evaluate my child for possible services with HCBS waiver, Care Management, Non-Medicaid Care Coordination, Community Residence, and/or other support services as mentioned above in the description. Upon determination of eligibility, my child will be receiving services from one of the above.

A. I hereby authorize the release and review of the Universal Referral Form application and all confidential information provided by my child's referral source to New York City Department of Health and Mental Hygiene working in NYC's Children's Single Point of Access program, to conduct eligibility determination and care coordination activities. I authorize New York City Health Department, under NYC's Children's Single Point of Access program, to release the above information to the person/organization/faculty/program identified above to make recommendations for the appropriate program for possible enrollment for my child. I also authorize the CSPOA specialist to check the Medicaid Analytics Performance Portal (MAPP) to determine my child's enrollment in a program. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by NYC Children's Single Point of Access. I am aware that revocation will not be effective if the persons I have authorized to use and/or disclose my child's health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my or my child's abilities to obtain services from the New York State Office of Mental Health including: Community Residence, Home and Community Based Services waiver and Non-Medicaid Care Coordination; nor will it affect my or my child's eligibility for benefits.
6. I have a right to inspect and copy my child's health information to be used and/or disclosed in accordance with the requirements of the federal privacy protection regulations found under 45 CFR§164.524.

AUTHORIZATION FOR RELEASE OF INFORMATION

B. Periodic Use/Disclosure: I hereby permit the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as necessary to fulfill the purpose identified above. I hereby understand that I have the right to revoke my authorization to release information by writing the NYC's Children's Single Point of Access at:

NYC Children's Single Point of Access
New York City Department of Health and Mental Hygiene
Bureau of Children, Youth & Families
42-09 28th street
Long Island City, NY 11101

I understand that this authorization will expire when my child is no longer receiving one of the intensive high-end mental health services.

C. **Patient Signature:** I certify that I authorize the use of my medical/mental health information as set forth in this document.

Signature of Patient or Personal Representative _____ Date _____

Patient's Name (Printed) _____

Personal Representative's Name (Printed) _____

Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Authorization)* _____

D. **Witness Statement/Signature:** I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY: _____
Staff Person's Name and Title

Authorization Provided to: _____

Date: _____

To be completed by facility:

Signature of Staff Person Using/Disclosing Information _____

Title _____

Date Released _____

Notice - Prohibitions on re-disclosure of substance abuse treatment records:
This notice pertains to disclosure of information concerning a patient's substance abuse treatment, made to you with the consent of such patient or patient's personal representative. This information, substance abuse treatment records, has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and the Health Insurance Portability and Accountability Act (HIPAA). The Federal rules prohibit you from making any disclosure of this information to organizations not listed in Part 1 above, unless further disclosure is expressly permitted by the written consent of the person to who it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in **Part 1**, to the person/organization/facility/program whose name and address is:

_____

_____

I hereby refuse to authorize the use/disclosure indicated in **Part 1**, to the person/organization/facility/program whose name and address is:

_____

_____

Signature of Patient or Personal Representative _____ Date _____

Patient's Name (Printed) _____

Personal Representative's Name (Printed) _____

Description of Personal Representative's Authority to Act for the Patient ***(required if Personal Representative signs Authorization)*** _____