**Oneida County Department of Mental Health**

# Authorization for the Use and/or Disclosure of Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), the Oneida County Department of Mental Health may not use or disclose your protected health information (PHI) except as provided in our Notice of Privacy Practices without your prior authorization. Your signature on this form indicates you give Oneida County Department of Mental Health permission to use and/or disclose your PHI identified below with authorized individual(s) and/or agency. Disclosure of PHI can be written, electronic, or verbal. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

## SUBJECT OF PROTECTED HEALTH INFORMATION (CLIENT)

Name _____ Date of Birth _____ Telephone _____

Address _____ City _____ State _____ Zip _____

## RECIPIENT OF PROTECTED HEALTH INFORMATION

Name of Individual / Agency _____ Telephone _____

Address _____ City _____ State _____ Zip _____

## INDIVIDUAL / AGENCY BEING AUTHORIZED TO DISCLOSE PHI

Name of Individual / Agency _____ Telephone _____

Address _____ City _____ State _____ Zip _____

☐ **Two Way Release** By checking this box, I authorize the individuals/agencies named in this authorization, to disclose to each other, the PHI identified below on an ongoing basis for the duration of this authorization.

## DOCUMENTS AUTHORIZED FOR USE / DISCLOSURE *(Please Check All That Apply):*

| | | |
|---|---|---|
| ☐ A-SPOA/A Referral | ☐ Core History | ☐ Admission / Intake information |
| ☐ Psychiatric Evaluations | ☐ Housing History | ☐ Discharge Summary |
| ☐ Psychological Evaluations | ☐ Hospitalization History | ☐ Case Management History |
| ☐ Mental Status Exams | ☐ Forensic History | ☐ Case Management Service Plans |
| ☐ Risk Assessment Forms | ☐ Treatment History | ☐ Current Svc Plan / IEP |
| ☐ Medical History | ☐ Most Recent Medical Exam | ☐ Educational Reports |
| ☐ AOT History | ☐ Current Medications | ☐ Medication History |
| ☐ Recommendations | ☐ Recommendations | ☐ Other (please specify): |

## PURPOSE OR NEED FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION *(Check all that apply):*

| | |
|---|---|
| ☐ Expedite access to care | ☐ A-SPOA/A Referral |
| ☐ Coordinate care | ☐ Establish Program Eligibility |
| ☐ Referral for mental health services | ☐ Cross System Case Conference |
| ☐ AOT coordination of services | ☐ Other _____ |

**Oneida County Department of Mental Health**

## Authorization:

*I have read or had read to me this Authorization form. I have had an opportunity to ask questions. By signing this Authorization, I am confirming that it accurately reflects my wishes regarding use and disclosure of my Protected Health Information. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties who are also subject to the requirements of federal law to protect this information. I understand that this authorization will automatically expire:*

- ☐ One Year from the date of this form
- ☐ This is a One-time release
- ☐ 30 days after discharge from this sequence of treatment**.**

_____ _____
**Signature of Client** **Date**

_____ _____ _____
**Signature of person legally authorized to consent to disclosure** **Title or Relationship to Client** **Date**

_____ _____
**Witness** **Date**

## Declination:

*I understand that I am under no obligation to sign this authorization. Oneida County Department of Mental Health will not deny anyone assistance who chooses to decline authorization. I hereby decline this authorization.*

_____ _____ _____ _____
Signature Date Witness Date

## Revocation Section:

*I understand that I may revoke this authorization at any time by signing the revocation section and returning it to Oneida County Department of Mental Health. I further understand that any such revocation does not apply to the extent that persons authorized to use/disclose my health information have already acted in reliance on this authorization.*

*I hereby revoke this authorization*

_____ _____ _____ _____
Signature Date Witness Date

Oneida County dmh Department of Mental Health