



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):*

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

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

- | | |
|--|--|
| <input type="checkbox"/> Expedite access to care | <input type="checkbox"/> A-SPOA/A Referral |
| <input type="checkbox"/> Coordinate care | <input type="checkbox"/> Establish Program Eligibility |
| <input type="checkbox"/> Referral for mental health services | <input type="checkbox"/> Cross System Case Conference |
| <input type="checkbox"/> AOT coordination of services | <input type="checkbox"/> 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