NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

UPDATED - 11/2017

AUTHORIZATION/CONSENT FOR DISCLOSURE OF CLINICAL INFORMATION

Part A - Individual Whose Information is to be Released	
Name (Last, First, MI):	*Social Security # (last four digits):*
Date of Birth (MM/DD/YYYY):	*TABS ID# (if known):*
Part B -	
Organization Authorized to Make Requested Disclosure	*Person or Organization to Whom Records Will Be Disclosed (Include name, address or other available contact info)*
NYS OPWDD	

Part C - Records/Information to Disclose

OPWDD maintains the medical records, including patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to us by the other healthcare providers, of individuals who have applied for OPWDD services, and for individuals who have received or continue to receive OPWDD services.

I authorize the disclosure of all information maintained by OPWDD as described above. Include (indicate by initialing):

_____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information

I authorize the disclosure of all information maintained by OPWDD as described above, only for the time period from (insert date) _____ to (insert date) _____.

Part D - Purpose and Reason for Disclosure

You **must** check one of the following **and** indicate the reason and purpose for this disclosure of information:

☐ At the request of the individual for the purpose of: _____

☐ Other for the purpose and reason of (please describe): _____

Part E - Expiration of Authorization

This authorization expires (insert date or event): _____

Part F - Required Signature

1. I may revoke this authorization, in writing, at any time by notifying the person or entity I have authorized to use or disclose information as listed above. I understand that a revocation is not effective against actions taken by the person or entity named above before they received such revocation and to the extent that they have relied upon this authorization.
2. I understand that if the person or entity authorized to receive my health and clinical information is not a health care provider or health plan, the disclosed information may be re-disclosed and may no longer be protected by federal privacy regulations. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I may refuse to sign this form and my refusal to sign will not affect my ability to obtain treatment or payments except in some situations when such information is needed for payment and enrollment.
4. I may, in accordance with the OPWDD Privacy Policy, inspect or copy any information used or disclosed under this authorization upon written request.

I authorize disclosure of the above-specified information:

Signature:	*Printed Name:*	*Date:*

If the person signing this form is not the individual whose information is being disclosed, you **must** check one of the following to indicate your authority to act on their behalf:

☐ Parent of a child under the age of 18.

☐ Personal representative (You **must** describe your authority to act for the individual and attach documentation hereto):

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