AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

THIS AUTHORIZATION ALLOWS DIFFERENT AGENCIES TO COORDINATE CARE TO BETTER SERVE YOU AND/OR YOUR DEPENDENT CHILD. (This form complies with HIPAA, 42 C.F.R Part 2, and FERPA.)

A. INDIVIDUAL'S INFORMATION

Individual's Name_____ Request Date_____

Parent/Guardian _____ Date of Birth_____/_____/_____

Mailing Address_____

City/State/Zip_____ E-mail _____

Telephone Numbers_____

B. AUTHORIZATION FOR ROCKLAND COUNTY AGENCIES

I hereby authorize the following four (4) Rockland County Agencies to release to each other the confidential information specified below, and any non-confidential information in the possession of said agencies, concerning the individual named above:

1. Rockland County BOCES
2. Rockland County Department of Probation
3. Rockland County Department of Social Services
4. Rockland County Department of Mental Health

C. AUTHORIZATION FOR OTHER, NON-COUNTY AGENCIES

I hereby authorize the following agencies to release the confidential information specified below, and any non-confidential information, in their possession to the four (4) above-named Rockland County Agencies concerning the individual named above. I further authorize the four (4) above-named Rockland County Agencies to release the confidential information specified below, and any non-confidential information, in their possession to the following agencies as needed for the coordination of care for the individual named above:

Name _____ Address _____

Name _____ Address _____

Name _____ Address _____

Name _____ Address _____

D. TYPES OF GENERAL RECORDS TO BE RELEASED

I hereby authorize the release of the following specific confidential information:
(Place an "X" in the box(es) below that apply to the information you want to be released.)

☐ School grades, behavior and attendance records ☐ Legal history ☐ Medical history ☐ Treatment

☐ Evaluations/Assessments ☐ Medications ☐ Immunizations ☐ Hospital Records ☐ MR/DD Reports

☐ Other: _____

E. RELEASE OF SPECIAL, PRIVILEGED INFORMATION & RECORDS

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, I hereby authorize the release of the following specific confidential information:
(Place an "X" in the box(es) below that apply to the information you want to be released.)

☐ Medical Records _____ (Initials)
☐ Drug Abuse and/or Assessments _____ (Initials)
☐ Vocational Rehabilitation _____ (Initials)
☐ Sexually Transmitted Diseases _____ (Initials)
☐ Arrest History _____ (Initials)
☐ Education records _____ (Initials)
☐ Alcohol Abuse and/or Assessments _____ (Initials)
☐ HIV (AIDS) _____ (Initials)
☐ Psychotherapy Notes _____ (Initials)
☐ Other: _____ (Initials)

PLEASE ALSO SIGN HERE FOR THESE DISCLOSURES: _____

F. REVOCATION, EXPIRATION & ACKNOWLEDGMENT

I understand I can revoke this authorization in writing at any time by contacting the person/agency who had me sign this form. I understand that revocation does not affect past disclosures. I further understand that if I do not specify an expiration date, this authorization will expire one year from the date of signature of this authorization.

Expiration: _____

I acknowledge that I have read pages 1, 2 and 3 of this three-page form.

_____ _____
Signature of Individual Date

_____ _____ _____
Signature of Legally Authorized Representative (if required) Relationship to Individual Date

_____ _____
Signature of Witness Date

Important Information About Authorization

Purpose of this form: When required by law or policy, child and youth service agencies may only obtain, use and disclose your health information if the required written authorization includes all the elements of a valid authorization (pursuant to FERPA, HIPAA, and 42 CFR Part 2).

An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment, payment, enrollment in a health plan, or eligibility for health care services. If you do not agree to release information required to coordinate services, we may not be able to provide the most effective services and/or programs.

If you agree to sign this authorization to release information, you will be given a signed copy of this form. Upon request, you will be provided with a copy of the records that are released.

A separate signed authorization is required for the use and disclosure of health information for psychotherapy notes, employment-related determinations by an employer, and research purposes unrelated to your treatment. You may be required to sign an authorization before receiving research-related treatment.

If your authorization is required by law or policy, the children and youth service agencies will only use and disclose your health information as you have authorized on the signed form.

You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. For example, in a juvenile court proceeding where a parent is required to obtain a psychological evaluation of his/her minor, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes).

You may cancel an authorization in writing at any time by contacting the person(s) who initiated this release. The agencies involved in your case cannot take back any uses or disclosures already made before an authorization was cancelled.

Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by state and federal privacy policies.

[To recipient of drug and alcohol patients: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom 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.]