AUTHORIZATION FOR RELEASE OF INFORMATION

For use by Northern Rivers Family of Services and member agencies

Client Name _____ Date of Birth _____
Last First Middle Alias

Program/Site _____ Discharge Year _____
If applicable

I, or my authorized representative, request that health information regarding my care and treatment, including behavioral and mental health, be used or disclosed as set forth on this form, in accordance with New York state law, the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the federal confidentiality law and regulations, 42 USC §290dd-2, 42 CFR Part 2.

Print name and address of provider or entity who is releasing the information

Name of Individual/Agency _____ Phone Number _____

Address _____
Number & Street Name City State ZIP

Print name and address of person(s) to whom this information will be sent to

Name of Individual/Agency _____ Phone Number _____

Address _____
Number & Street Name City State ZIP

Note: Government-issued ID required for documents released to clients.

Authorization to discuss protected health information

☐ By checking this box, I authorize Northern Rivers Family of Services to ***discuss*** my health information with the person/health individual or agency mentioned above.

Please check the box below if you want to include your information related to (please check all that apply):

☐ HIV/AIDS
☐ Alcohol and/or drug abuse treatment
☐ Reproductive health
☐ Sexual abuse evaluation/sexual behavior assessment

Date or event on which this authorization will expire: _____

Description of Information to be used or disclosed (please check all that apply):

☐ Psychiatric assessments and impressions
☐ Psychosocial assessments
☐ Psychological assessments
☐ Comprehensive and family assessments
☐ Treatment and service plans
☐ Medical assessments and/or treatment summaries
☐ Behavioral assessments and plans
☐ Diagnostic evaluation and case summaries
☐ Discharge and treatment summaries
☐ Educational records
☐ Other (specify): _____
☐ Other (specify): _____

Reason for release of information (please check all that apply):

☐ At request of individual
☐ Assessment
☐ Service and/or treatment planning
☐ Service coordination
☐ Discharge planning
☐ Other (specify): _____
☐ Other (specify): _____
☐ Other (specify): _____

PLEASE COMPLETE BOTH SIDES OF THIS DOCUMENT

NORTHERNRIVERS
60 Academy Road, Albany, NY 12208
p. 518.426.2600 f. 518.426.2835
www.northernrivers.org

Issued 03/21

Client Name _____ Date of Birth _____

My signature below indicates that I understand the following:

1. I may revoke this authorization in writing at any time, except to the extent Northern Rivers Family of Services has taken action in reliance on this authorization and send to the Privacy Officer at 60 Academy Road, Albany, NY 12208 or the program supervisor.

2. This authorization is voluntary and Northern Rivers Family of Services may not condition treatment or benefits on my willingness to sign this authorization.

3. I have a right to a signed copy of this authorization.

4. Any information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by law ***unless*** this information is related to HIV/AIDS, consists of the records of a federally assisted substance and alcohol abuse program, or consists of records of a New York state–licensed mental health facility, in which case the information may be redisclosed only in accordance with applicable laws governing such information or records.

5. If this information relates to HIV/AIDS, I may ask for a list of people who can be given my confidential HIV-related information without a release form. If I experience discrimination because of the release of HIV-related information, I may contact the New York State Division of Human Rights at 888.392.3644 or the New York City Commission on Human Rights at 212.306.7450. These agencies are responsible for protecting my rights.

I have read and fully understand this authorization form. Proof of identity may be required. By signing below, I authorize Northern Rivers Family of Services to use and/or disclose my protected health information of behavioral/mental health consistent with the terms of this authorization.

_____ _____ _____
Name of individual or legal guardian (please print) *Signature* *Date*

Authority to sign: ☐ Client ☐ Parent ☐ Legal guardian

_____ _____ _____
Name of individual or legal guardian (please print) *Signature* *Date*

Authority to sign: ☐ Client ☐ Parent ☐ Legal guardian

_____ _____
Name of individual health care provider requesting the information (please print) *Date*

If disclosing the following type of data, consent and signature from a minor client is required. Check all that apply:

☐ Mental health (12 years and older – NY Mental Hygiene Law § 33.16)
☐ Substance abuse ☐ Reproductive health
☐ HIV ☐ Sexual trauma

_____ _____
Signature of minor client *Date*

NOTICE TO ACCOMPANY DISCLOSURE OF HIV-RELATED INFORMATION

This information has been disclosed to you from records protected by State law. State law prohibits you from making any further disclosure of this information without the express written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure of this information.

NOTICE TO ACCOMPANY DISCLOSURE OF ALCOHOL/DRUG INFORMATION

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 disclosure 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.

PLEASE COMPLETE BOTH SIDES OF THIS DOCUMENT