REQUIRED CONSENT FOR RELEASE OF INFORMATION

This form must be reviewed and signed by the patient (child) or their personal representative. If the patient is less than 18 years old, the parent (or guardian) of the patient must review and sign this form. This form permits the use and disclosure of health information, substance abuse treatment information and mental health information for the purposes of planning, care coordination and delivery of services for the child referred for intensive mental health services. A separate form is required to use or disclose confidential HIV-related information.

Person whose information may be used or shared:

Child's Name:_____ Date of Birth:_____
(referred in this document as "my child" or "your child")

PART 1: Required Consent to Release Information

A. Description of Information to Be Used or Shared:

The information about your child that will be used or shared includes: the Children's Single Point of Access (CSPOA) application, educational, medical and substance abuse treatment, and mental health assessments, including: psychiatric and psychological evaluations, psychosocial assessments, discharge reports, all relevant clinical data and other: _____.

I hereby authorize my child's referral source to share the CSPOA application and all confidential information (including my child's mental health information, psychiatric and psychosocial evaluation, substance abuse treatment information and medical information) to New York City Department of Health and Mental Hygiene (the Health Department) through New York City's (NYC) CSPOA program. I hereby authorize the Health Department's CSPOA to use and share this information to determine eligibility and care coordination activities for my child.

B. Purpose or Need for Information: Your child has been referred for intensive mental health services. CSPOA determines eligibility and care coordination activities for children in need of intensive mental health services. A CSPOA specialist must review information from application and other information described above so that the right services may be provided to your child.

C. You authorize CSPOA to share your child's information with the following person(s), organization(s), facility(ies) or program(s) and to use your child's information as described below:

To determine eligibility and care coordination activities for your child, a CSPOA specialist will:

- contact you, in addition to the referral source, including the person who completed the evaluations, to discuss treatment for your child; and
- share the information described above with a variety of agencies and organizations that are contracted through the New York State Office of Mental Health, the NYC Health Department, State Department of Health or Health Homes Servicing Children (including Health Home Care Management) to make recommendations for the appropriate program for possible enrollment for intensive mental health services. The agencies and organizations that may receive your child's information include the following: care management agencies, Non-Medicaid Care Coordination providers, Health Home Care Management care managers. In addition, you understand that referrals may be discussed with and provided to the following agencies or programs: Office of Persons with Developmental Disabilities, the

Family Resource Center, Intensive Crisis Stabilization and Treatment, Home-Based Crisis Intervention, Functional Family Therapy (FFT), the New York State Office of Children and Family Services, the Local Department of Social Services and the Pre-Admission Certified Committee; and

- check the Medicaid Analytics Performance Portal (MAPP) to determine your child's enrollment in a program.

D. My Rights: I understand that:

1. I have the right to cancel my permission to release the information or withdraw from the referral process at any time by contacting the NYC CSPOA Administrative Office at 347-396-7205.
2. Only this information may be used and disclosed as a result of this consent.
3. This information is confidential and cannot legally be disclosed without my permission.
4. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.
5. I have the right to revoke (take back) this consent at any time. Taking back consent must be in writing on the form provided to me by NYC's CSPOA. I am aware that taking back consent will not apply if the persons I have authorized to use and disclose my child's health information have already taken action because of my earlier consent. To take back consent, I will write to NYC's CSPOA at:

   NYC Children's Single Point of Access
   New York City Department of Health and Mental Hygiene
   Bureau of Children, Youth and Families
   42-09 28th St.
   Long Island City, NY 11101

6. I do not have to sign this consent and that my refusal to sign will not affect my abilities or my child's abilities to get services from the New York State Office of Mental Health including: Community Residence, Health Home Care Management and Non-Medicaid Care Coordination; nor will it affect my eligibility or my child's eligibility for benefits.
7. I have the right to review and copy my child's health information to be used and disclosed according to the requirements of the federal privacy protection regulations found under 45 CFR§164.524.
8. I understand that this consent will expire when my child is no longer receiving one of the intensive mental health services.

E. Periodic Use and Disclosure: I hereby permit the periodic use and disclosure of the information described above to the person, organization, facility or program identified above as necessary to fulfill the purpose identified above.

PART 2: Signature

Patient Signature: I certify that I authorize the use of my child's medical and mental health information as set forth in this document.

_____ _____
Signature of Patient (or Representative authorized by law) Date

_____
Patient's Name (Printed)

_____
If signed by Representative, Representative's (or Parent's or Guardian's) Name (Printed)

_____
If signed by Representative, describe Representative's authority to sign on behalf of the Patient *(for example, put "parent" if Representative is the parent of minor patient)*

D. **Witness Statement and Signature:** I have witnessed the execution of this consent and state that a copy of the signed consent was provided to the patient or the patient's personal representative.

WITNESSED BY: _____
Staff Person's Name and Title

Consent Provided to: _____
Patient's Name

Date: _____

To be completed by facility: _____
Signature of Staff Person Using and Disclosing Information

_____
Title

_____
Date Released

Notice - Prohibitions on re-disclosure of substance abuse treatment records:
This notice pertains to disclosure of information concerning a patient's substance abuse treatment, made to you with the consent of such patient or patient's personal representative. This information, substance abuse treatment records, has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and the Health Insurance Portability and Accountability Act (HIPAA). The Federal rules prohibit you from making any disclosure of this information to organizations not listed in Part 1 above, unless further disclosure is expressly permitted by the written consent of the person to who it pertains or as otherwise permitted by 42 CFR Part 2. A general consent 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.

PART 3: Taking Back Consent to Release Information

I hereby revoke my authorization to use and disclose information indicated in **Part 1**, to the person, organization, facility or program whose name and address is:

_____

_____

I hereby refuse to give consent for the use and disclosure indicated in **Part 1**, to the person, organization, facility or program whose name and address is:

_____

_____

_____ _____

Signature of Patient (or Representative authorized by law) Date

_____

Patient's Name (Printed)

_____

If signed by Representative, Representative's (or Parent's or Guardian's) Name (Printed)

_____

If signed by Representative, describe Representative's authority to sign on behalf of the Patient *(for example, put "parent" if Representative is the parent of minor patient)*

CSPOA Questions about Patient Information and Sharing Consent

1. How will CSPOA providers use my information?

If you agree, CSPOA providers will use your health information to:

- Coordinate your child's health care and manage your child's care
- Check if you have health insurance and what it pays for
- Study and make health care for patients better

The choice you make does NOT let health insurers see your information to decide whether to give you health insurance or pay your bills.

2. Where does my health information come from?

Your health information comes from places and people that gave your health care or health insurance in the past. These may include hospitals, doctors, drugstores, laboratories, health plans (insurance companies), the Medicaid program and other groups that share health information. For a list of the information available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider to print the list for you.

3. What laws and rules cover how my health information can be shared?

These laws and regulations include New York Mental Hygiene Law Section 33.13, New York Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (which are the rules referred to as "Health Insurance Portability and Accountability Act (HIPAA)").

4. If I agree, who can get and see my information?

The only people who can see your health information are those who you agree can get and see it, like doctors and other people who work for the CSPOA and who are involved in your child's health care and people who work for a CSPOA provider who is giving your child care to help them check your child's health insurance or to study and make health care better for all patients.

5. What if a person uses my information and I didn't agree to let them use it?

If you think a person used your child's information and you did not agree to give this person your child's information, you may call one of the providers you gave permission to see your records, the CSPOA at 347-396-7205, the United States Attorney's Office at 212-637-2800 or the New York State Office of Mental Health Customer Relations at 800-597-8481.

6. How long does my consent last?

Your consent will last until the day you take back your consent, if the CSPOA is discontinued or three years after the last date of service from the CSPOA, whichever comes first.

7. What if I change my mind later and want to take back my consent?

You can take back your consent at any time by signing a Withdrawal of Consent Form and giving it to the CSPOA. Call 347-396-7205 to get this form. Note: Even if you decide to later take back your consent, providers who already have your information do not have to take it out of their records.

8. How do I get a copy of this form?

You can have a copy of this form after you sign it.