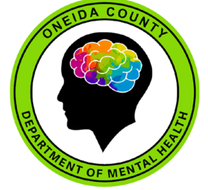
ONEIDA COUNTY
DEPARTMENT OF MENTAL HEALTH



ANTHONY J. PICENTE, JR.
County Executive

ASHLEE L. THOMPSON
Commissioner
Director of Community Services

HIPAA AUTHORIZATION FOR TWO-WAY EXCHANGE OF HEALTH INFORMATION
ADULT SINGLE POINT OF ACCESS (ASPOA)

This form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160; 45 CFR Parts 164; 42 CFR Part 2; 5 U.S.C. 552a; 38 U.S.C. 5701; and 38 U.S.C. 7332. Your disclosure of the information requested on this form is voluntary. The County of Oneida may disclose the information that you put on the form as permitted by law. Your signature on this form indicates you give the County of Oneida permission to use and/or disclose your Protected Health Information (PHI) identified below with authorized individual(s) and/or agencies. Disclosure of PHI may be written, electronic, or verbal. Authorization of this form includes the communication and disclose to/from/between all organizations that offer services through the Oneida County ASPOA Program to coordinate services on your behalf. These agencies include ACR Health, Building Blocks Learning Center, Catholic Charities Diocese of Syracuse - Oneida/Madison County, Central New York Health Home, Inc., County of Oneida (aka Oneida County Government), DePaul Properties, Inc., Helio Health, Inc., Integrated Community Alternatives Network (ICAN), Mohawk Valley Psychiatric Center, Neighborhood Center, Inc., Presbyterian Residential Community, Rescue Mission of Utica, Salvation Army and Upstate Cerebral Palsy dba Upstate Caring Partners.

**Asterix marked sections are required to be completed.

****FIRST NAME OF INDIVIDUAL**	****LAST NAME OF INDIVIDUAL:**
****DATE OF BIRTH *(mm/dd/yyyy):***	****PHONE #:**
INDIVIDUAL'S MAILING ADDRESS *(including City, State and Zip Code):*	

RECIPENT OF PROTECTED HEALTH INFORMATION (PRE-FILLED**):** ONEIDA COUNTY DEPARTMENT OF MENTAL HEALTH (OCDMH) 800 PARK AVENUE, UTICA, NY 13501	
****NAME OF AGENCY OR INDIVIDUAL BEING AUTHORIZED TO DISCLOSE PHI TO OCDMH:**	****PHONE # OF AGENCY OR INDIVIDUAL BEING AUTHORIZED TO DISLOSE PHI TO OCDMH:**
****ADDRESS OF AGENCY OR INDIVIDUAL BEING AUTHORIZED TO DISCLOSE PHI TO OCDMH:**	
THE PURPOSE FOR WHICH THIS INFORMATION MAY BE USED, DISCLOSED, OR REDISCLOSED INCLUDE (PRE-FILLED8**):** • TO DETERMINE INITIAL AND CONTINUING HOME & COMMUNITY BASED SERVICES SUCH AS RESIDENTIAL, CASE MANAGEMENT, ASSERTIVE COMMUNITY TREATMENT, CRISIS, TRANSPORTATION, VOCATIONAL, AND/OR EDUCATIONAL RESOURCES; • TO DETERMINE AND MAKE RECOMMENDATIONS FOR APPROPRIATE LEVELS OF CARE; • TO ASSIGN APPROPRIATE SERVICES OFFERED THROUGH PARTNERSHIPS WITH SINGLE POINT OF ACCESS (SPOA) PROGRAMS; • TO ACCESS DATA IN PSYCKES TO DETERMINE SERVICE ELIGIBILITY AND LEVEL OF SERVICE NEED; AND • TO PLAN AND COORDINATE SERVICES AND TREATMENT.	
****INFORMATION REQUESTED AND TO BE RELEASED (CHECK EACH APPLICABLE):** _____ ENTIRE MEDICAL/SERVICE RECORD (INCLUDING PSYCHIATRIC & SUBSTANCE USE RECORDS) **-OR-** _____ BEHAVIORAL/MENTAL HEALTH/OTHER PSYCHIATRIC SCREENINGS/ASSESSMENTS/EVALUATIONS _____ SUBSTANCE USE RECORDS	

_____ FORENSIC HISTORY & RECORDS
_____ LEGAL HISTORY & RECORDS
_____ MEDICAL INFORMATION/HISTORY/CONCERNS (INCLUDING LABWORK/CLINICAL PROCEDURES)
_____ LETHALITY/RISK ASSESSMENTS/SCREENINGS/CONCERNS
_____ DIAGNOSIS/PROGNOSIS/PROGRESS IN TREATMENT/SERVICES
_____ HOUSING HISTORY
_____ MEDICATION HISTORY
_____ CASE MANAGEMENT RECORDS
_____ ADMISSION/INTAKE INFORMATION
_____ SERVICE PLAN(S)/IEP
_____ HIV/AIDS RELATED INFORMATION
(For HIV/AIDS disclosure: *I understand I also need to complete Form DOH 2557 found on the NYS Department of Health website.*

_____ OTHER: ____
____
____
____

AUTHORIZATION:
I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. This authorization is signed with the express understanding that the released information shall not be used for any purpose other than to provide and coordinate behavioral health services and shall be used in a confidential manner. I understand that I can receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the County of Oneida – Department of Mental Health. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. **I understand this disclosure includes future generated records 24 months after the date of my signature unless specified otherwise in the "expiration" section. Further, I understand that these records may be redisclosed amongst the providers who provide SPOA services in Oneida County, NY.**

EXPIRATION (IF NONE – SKIP THIS SECTION):
Only fill out this part if you are placing limitations on the expiration of permissions and/or limitations on permission)
UPON THE FOLLOWING DATE: ____
UPON THE FOLLOWING EVENT: ____

****SIGNATURE OF INDIVIDUAL:**

I am the person, or personal representative of the person, whose records will be used, disclosed and/or re-disclosed. I give permission to use, disclose and/or re-disclose my records as described in this document

DATE:

****FIRST NAME OF INDIVIDUAL**	****LAST NAME OF INDIVIDUAL:**