NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

Attachment 1

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

REVOKED ON_____ **Staff Signature**_____

PATIENT'S LAST NAME ,	FIRST	M.I.
CASE NO.		
FACILITY	UNIT	

INSTRUCTIONS:	**GIVE A COPY OF THE FORM TO THE PATIENT!** Prepare one (1) copy for the Patient's Case Record. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE]/ [RELEASE] WITH PATIENT'S CONSENT (CIRCLE)

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

I consent to my personally identifying information, including but not limited to, Medicaid client identification number (CIN), to be provided to the New York State Department of Health; the Office of Temporary and Disability Assistance; The Office of Alcoholism and Substance Abuse Services (OASAS) and the identified Local Social Services District including the patient's District of Fiscal Responsibility (* See list below).

* Local Social Services Districts:

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

This communication is necessary to facilitate, where permitted (e.g. client is Medicaid eligible) Medicaid fee for service reimbursement for services delivered by the Chemical Dependence Residential Rehabilitation Services for Youth (RRSY) program and other Medicaid services that may be provided outside of the RRSY program.

NAME OF PERSON OR TITLE OF ORGANIZATION DISCLOSING/RELEASING INFORMATION Between:	NAME OFPERSON OR TITLE OF ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE And:

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire two (2) years from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above:

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NOTE:	Any information released through this form will be accompanied by the form Prohibition on re-disclosure of Information Concerning Alcoholism/Drug Abuse Patient (TR-1 [A-4400])

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____ (Signature of Patient)

_____ (Signature of Parent/Guardian, when required)

_____ (Print Name of Patient)

_____ (Print Name of Parent/Guardian)

_____ (Date)

_____ (Date)