Authorization For Release of Information

Name of individual:	Date of Birth:
Address:	

❒ I, or my authorized representative request that my information (identified below) **<u>be released TO</u> Person Centered Services CCO** from (name and address):

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❒ I, or my authorized representative request that my information (identified below) **<u>be released BY</u> Person Centered Services CCO** to (name and address):

____

I request the following to be disclosed:	My Protected Health Information is being disclosed for the following purposes:
❒ All Protected Health Information ❒ All Educational Information ❒ Only ______________________________ ❒ All Protected Health Information, <u>except</u>: ____ ❒ Mental Health Information ____________ MUST INITIAL	❒ To help me manage my care, treatment and services. ❒ For other purpose(s) (please specify): ____

I understand that according to New York State Law and HIPAA:

- If I refuse to sign this authorization, Person Centered Services will not deny me any care, treatment or services except in limited circumstances and I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
- Information that is disclosed under this Authorization may be disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.
- I understand I may revoke this authorization at any time by submitting a written revocation but that my revocation will not have any effect on action already taken in reliance on this authorization.
- I understand this authorization is effective through the period of time I am receiving services from Person Centered Services unless revoked earlier by me or my personal representative.
- I understand that a separate authorization form will be required for the disclosure of PHI that includes Alcohol/drug Treatment covered under 42 CFR Part 2 or HIV related information.
- If I checked the box and affixed my initials authorizing the disclosure of mental health information, I specifically authorize that information be disclosed.

I have read and understand the terms of this authorization and have had an opportunity to ask questions.

Name of person signing form (Print)	Date
Signature	Relationship to Individual (ex. self, guardian, parent)

Date Last Revised: 1/20/2022