Cattaraugus County Department of Social Services' Financial Services Unit: CONSENT TO OBTAIN AND RELEASE PSYCHIATRIC, SUBSTANCE ABUSE, EDUCATIONAL, DEVELOPMENTAL DISABILITY, PROBATION, SOCIAL SERVICES ADULT SERVICES, AND OTHER SERVICE INFORMATION FOR ADULTS INVOLVED IN MULTIPLE SYSTEMS OF CARE.

Name (Last, First, M.I.) "C" No.

Sex ____ Date of Birth ____/____/____

Consent to Release Information

Consent form: Department of Social Services' Financial Services Units One Leo Moss Dr., Olean, NY 14760 are hereby granted permission to release and/or obtain information from my medical treatment, education, probation or service records to and from: **CASA-Trinity , Cattaraugus County Dept. of Community Services, Cattaraugus County Dept. of Social Services' Adult Services Units, Cattaraugus County Probation Dept, NYS Department of Corrections, Veterans' Services, Cattaraugus One Stop Career Center, NYS Department of Labor, Jamestown Community College, Greater Olean, Inc, ACCES-VR, Literacy Volunteers , Cattaraugus County Dept. of Health, including the Early Intervention Program, Directions for Independent Living, Head Start/Even Start programs, Healthy Families, Seneca Nation of Indians, including, Seneca Nation Health Dept., Connecting Communities in Action, Genesis House, Accord Corp., BOCES**

OTHER: _____ EXCEPTIONS TO ABOVE: _____

The information to be disclosed is: _____
I understand that this record and/or referral may contain information about my identity, diagnosis, treatment, prognosis, and may contain information about psychiatric and/or substance abuse diagnosis.
The purpose or need for disclosing and obtaining information is: To assess and facilitate appropriate services and to coordinate services and case planning for purposes of increasing employability and/or securing shelter.
I am not giving permission for any re-disclosure of this information other than specified above.

INSTRUCTIONS: Patient, guardian, or person acting for the patient **must sign** A to give permission for the release of information and to authorize permission for review by the Department of Social Services' Financial Units. Also, mark either six months or 365 days as preferred or required. **B** is signed only when there is *denial* of permission.

A. My consent will expire in 365 days ____ or six months ____ ***(Mark one or the other)*** as I grant permission for the exchange of information to the parties authorized above. I also understand that I have the right to cancel my permission to release or obtain information at any time.
I hereby authorize the Department of Social Services' Financial Services Units to review all relevant records for the purpose of determining appropriate services and case planning. I understand that Department of Social Services' Financial Services Units' members will hold all information pertaining to myself in confidence. The information will be disclosed from records protected by Federal Confidentiality Rules & the Health Insurance Portability and Accountability act of 1996. These regulations prohibit any further disclosure of information unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted under these regulations. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug client/patient.

	Relationship (to patient)	Date		Title	Date
_____ Signature of patient			_____ Signature of Witness		
_____ Signature of guardian/responsible party			_____ Signature of Witness		

B. *I hereby refuse to authorize the release of information to the person/organizations, facilities, or programs above.*

	Relationship (to patient)	Date		Title	Date
_____ Signature of patient			_____ Signature of Witness		
_____ Signature of parent/guardian/responsible party			_____ Signature of Witness		