400 Doansburg Road
Brewster, NY 10509
845-279-2995
www.greenchimneys.org

green chimneys

AUTHORIZATION FOR THE USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION

Child's Name:_____ Date of Birth: _____

Personal Representative (Parent or Legal Guardian): _____

Relationship to Child: _____

I hereby authorize GREEN CHIMNEYS to use or disclose protected health information about me in accordance with the following terms and conditions:

Description of information to be used or disclosed:

☐ Educational records

☐ Medical records

☐ Discharge records

☐ Verbal exchange of information

☐ Specific records (please list):

_____

Please check which, if any, apply:

☐ This information is related to HIV/AIDS

☐ This information contains records of a licensed mental health facility

☐ This information contains records of a federally assisted alcohol or drug abuse treatment program

Individuals or entities to whom the information may be disclosed:

_____

Purpose of the use or disclosure:

_____

Date or event upon which this authorization will automatically expire unless previously revoked:

_____

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My signature below indicates that I understand the following:

(1) I may revoke this authorization in writing any time, except to the extent GREEN CHIMNEYS has taken action in reliance on this authorization.
(2) This authorization is voluntary and GREEN CHIMNEYS may not condition treatment or benefits on my willingness to sign this authorization, except if my treatment is related to research or involves services provided to me solely for the purpose of creating information for disclosure to a third party.
(3) I have a right to a signed copy of this authorization.
(4) Any information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by law unless this information is related to HIV/AIDS, consists of the records of a federally assisted substance and alcohol abuse program or consists of records of a New York State-licensed mental health facility, in which case the information may be re-disclosed only in accordance with applicable laws governing such information or records.
(5) If this information relates to HIV/AIDS, I may ask for a list of people who can be given my confidential HIC related information without a release form.
(6) If I experience decimation because of the release of HIV-related information, I may contact the New York State Division of Human Rights at (212) 961-8624 or the New York City Commission on Human Rights at (212) 566-5493. These agencies are responsible for protecting my rights.

I have read and fully understand this authorization form. By signing below, I authorize GREEN CHIMNEYS to use and/or disclose any protected health information consistent with the terms of this authorization.

_____

Name of Personal Representative (Parent or Legal Guardian)

_____ _____

Signature Date