

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Purpose of this Authorization Form

This form gives permission to share your personal information with specific people or organizations. By signing this form:

- You agree to allow certain information, such as verbal exchange of communication, discharge records, medical records, or educational records, to be shared with people you choose
- You control what's shared — only the information listed in this form will be shared, and only with the people listed
- Your privacy is protected — information will only be shared when needed, and only for the reasons stated here
- You are protected by the law — sharing your information in this manner meets legal requirements for protecting your health and school records (HIPAA and FERPA)

You can cancel this permission at any time by request in writing. This permission will last until the expiration date listed in this form, unless you cancel it sooner. Please note that if information was already shared before you canceled, that cannot be undone.

Prefer to sign online? Email us at jcarvalho@greenchimneys.org and we will send you a digital copy of this form through Adobe Sign. You can fill it out and sign it on your computer, tablet, or phone.

***Please note that IEPs and Official Transcripts must be requested from the client's school district. ***

Please complete all parts of this form and submit via email to apereira@greenchimneys.org

Or mail to: Quality Improvement Office
Green Chimneys
400 Doansburg Road
Brewster, NY 10509

For any questions, please email apereira@greenchimneys.org.

CLIENT INFORMATION

Client Name and Date of Birth	
Program	<input type="checkbox"/> RTC TDS-B TDS-C Other: _____
Your Name (parent/guardian/power of attorney)	
Your Relationship to the Client (for power of attorney, send documentation to apereira@greenchimneys.org)	
Your phone number and email	
Start Date: The earliest date of the records or information you want to share	
Who should receive this information List name, address, and contact information of each person or organization you are giving permission to.	
Expiration Date: What date should this form automatically expire? (Date permission ends on its own, unless canceled sooner)	

I. WHY IS THIS INFORMATION BEING SHARED?

II. AUTHORIZATION

I hereby authorize GREEN CHIMNEYS to use or disclose protected health or education information in accordance with the following terms and conditions (select all that apply):

III. WHAT INFORMATION CAN BE SHARED?

Discharge Records	<input type="checkbox"/> Psychiatric Treatment Summary (RTC only) <input type="checkbox"/> Social History Update <input type="checkbox"/> Education Discharge Teacher Report
Educational Records	<input type="checkbox"/> Report Card <input type="checkbox"/> Psychoeducational Report <input type="checkbox"/> Attendance <input type="checkbox"/> OT/Speech Notes/Evaluations <input type="checkbox"/> Related Services Reports <input type="checkbox"/> FBA/BIPs
Medical Records	<input type="checkbox"/> Psychiatric Notes <input type="checkbox"/> Visits/Consults/Labs <input type="checkbox"/> Annual Physical <input type="checkbox"/> Medication Records <input type="checkbox"/> Immunization Record
Other	<input type="checkbox"/> Verbal Exchange of Information <input type="checkbox"/> Comprehensive Treatment Plans
Specific Records (please indicate)	
Please check if any apply	<input type="checkbox"/> This information is related to HIV/AIDS <input type="checkbox"/> This information contains records pertaining to mental health assessment and treatment <input type="checkbox"/> This information contains records pertaining to alcohol or drug abuse assessment or treatment

IV. HOW WOULD YOU LIKE COPIES PROVIDED?

- Mail (*May include postage costs*) Secure Email (*Depended on size of record*)
 Fax Pick up at Green Chimneys

V. PLEASE READ BEFORE SIGNING

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 HIV related information without a release form.
6. If I experience discrimination 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.
7. Records will only be released to parties other than the eligible student or the student's parent/guardian upon submission of valid proof of power of attorney or other legally sufficient authorization.

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 if applicable): _____ **Date:** _____