





**REQUIRED CONSENT FOR RELEASE OF INFORMATION  
for Single Point of Access (SPOA), \_\_\_\_\_ County ("County")**

This authorization must be completed by the referred individual or his/her legal guardian/personal representative. This authorization permits the use, disclosure and re-disclosure of Protected Health Information (PHI) in accordance with State and Federal laws and regulations that govern the release of confidential records, as well as Title 42 of the Code of Federal Regulations that governs the release of drug & alcohol records for the purposes of care coordination, delivery of services, payment for services, and health care operations.

**I AUTHORIZE communication with, and an exchange of Personally Identifying Information (PII) and PHI** between, the County Single Point of Access (SPOA) team (comprised of County and state employees as well as representatives of local service providers), Other Provider(s) (see attached list of Providers on page 2); **AND** the Referral Source (Person / Title / Agency / School or Correctional Facility):

**DESCRIPTION OF INFORMATION** to be used / disclosed and re-disclosed (*check ALL that apply*):  **ALL listed below**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Referral (including contact info)     | <input type="checkbox"/> Inpatient/Outpatient Treatment    | <input type="checkbox"/> Diagnosis                          |
| <input type="checkbox"/> Psychiatric Evaluation/Assessment     | <input type="checkbox"/> Financial &/or Insurance Info     | <input type="checkbox"/> Physical Health                    |
| <input type="checkbox"/> Mental Health/Psychosocial Assessment | <input type="checkbox"/> Discharge Summary/Treatment Plan  | <input type="checkbox"/> Medications (past & present)       |
| <input type="checkbox"/> Psychological &/or Neurological Tests | <input type="checkbox"/> Pre-Sentence Investigation Report | <input type="checkbox"/> Substance Use                      |
| <input type="checkbox"/> Documentation of Medical Necessity    | <input type="checkbox"/> HIV/AIDS-related Information      | <input type="checkbox"/> School Records (including testing) |
| <input type="checkbox"/> Psychosocial History and Assessment   | <input type="checkbox"/> Other (specify): _____            |   |
| <input type="checkbox"/> Family Planning Information           |  |   |

**PURPOSE OR NEED FOR INFORMATION:**

**Allow SPOA to:** make referrals to appropriate providers; consult regarding care; participate in care management services; provide discharge planning information to the providers listed on page 2; coordinate care among providers and through Health Homes; and facilitate participation in services accessed through SPOA.

**I UNDERSTAND and ACKNOWLEDGE:**

- This information must not be used, disclosed, or re-disclosed for any other purpose not covered under this authorization;
- With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of information related to HIV/AIDS-related, alcohol or drug treatment, or mental health treatment, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law or regulation;
- I am authorizing the re-disclosure of above-described information to the providers identified on page 2 of this form for the purposes identified on this form;
- I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on a form provided by **County**. I am aware that my revocation does not affect information disclosed while the authorization was in effect;
- I do not have to sign this authorization and that my refusal to sign will neither affect my ability to obtain treatment, nor my eligibility for benefits;
- I have the right to inspect and copy my own PHI to be used/disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR § 164.524);

**I HEREBY AUTHORIZE** the use, disclosure, and re-disclosure of the indicated PHI by and to the parties identified on this release as often as necessary to fulfill the purpose(s) identified above, and this authorization will expire: (check one)

When the individual named herein is no longer receiving services from County SPOA;

One Year from the date of signature;

Other: \_\_\_\_\_

**I CERTIFY THAT I AUTHORIZE** the use of the PHI as set forth in this document. By signing this authorization, I acknowledge that I have read and understand it. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability from the disclosure of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
SIGNATURE of Individual, Parent or Legal Guardian

\_\_\_\_\_  
Printed Name of Individual signing

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Authority of Personal Representative

\_\_\_\_\_  
SIGNATURE of WITNESS

\_\_\_\_\_  
Printed Name of Witness/Title

\_\_\_\_\_  
Date



COMMUNICATION PREFERENCES

County SPOA wants to respect your wishes regarding Communication. Please indicate your preferences below.

US Mail

Can we send mail to your address with our return address on the envelope? Yes No

Telephone:

When calling, can we say we are County SPOA (Single Point of Access)? Yes No

PERMISSION FOR ELECTRONIC COMMUNICATION

I understand the transmission of electronic information may not be secure. E-mails and cell phone communications are unencrypted, and other concerns may exist including but not limited to: email and faxes may accidentally be sent to the wrong person; content may be changed without knowledge; copies may exist; some e-mails may contain harmful viruses; cell phone communications may be intercepted or heard by others; texting leaves a record of communication; and there is a risk of loss of device with information on it.

BY SIGNING BELOW, I HEREBY AUTHORIZE County Mental Health SPOA Team permission to correspond with me via (check all that apply):

- FAX Fax Number:
E-MAIL Email Address:
CELL PHONE Phone Number:
TEXT MESSAGE Phone Number:

I understand this permission may be cancelled by me at any time but cannot apply retroactively to communication that has already been sent.

SIGNATURE of Individual, Parent or Legal Guardian Printed Name of Individual signing Date

Description of Authority of Personal Representative

SIGNATURE of WITNESS Printed Name of Witness/Title Date

**Optional Children's Single Point of Access (C-SPOA) Patient Information Retrieval Consent**

\_\_\_\_\_  
Name of SPOA County

The SPOA Committee may get health information, including your child’s health records, through a computer system run by \_\_\_\_\_, a Regional Health Information Organization (RHIO). A RHIO uses a computer system to collect and store health information, including medical records, from your child’s doctors and health care providers who are part of the RHIO. The RHIO can only share your child’s health information with people who you say can see or get such health information.

The SPOA Committee may also get health information, including your child’s history of services reimbursed by Medicaid through a computer system called PSYCKES, which is run by the New York State Office of Mental Health. PSYCKES is a computer system maintained by the New York State Office of Mental Health that contains health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in PSYCKES, visit [www.psyckes.org](http://www.psyckes.org) and see “About PSYCKES.”

If you agree and sign this form, SPOA Committee members are allowed to get, see, read and copy ALL of your child’s health information (including all of the health information obtained from the RHIO and/or from PSYCKES) that they need to arrange your child’s care, manage such care or study such care to make health care better for patients. The health information they may get, see, read and copy may be from before and after the date you sign this form. Your health records may have information about illnesses or injuries your child had or may have had before; test results, like X-rays or blood tests; and the medicines your child is now taking or has taken before. Your child’s health records may also have information on:

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Alcohol or drug use problems</li> <li>• Birth control and abortion (family planning)</li> <li>• Genetic (inherited) diseases or tests</li> <li>• HIV/AIDS</li> </ul> | <ul style="list-style-type: none"> <li>• Mental health conditions</li> <li>• Sexually transmitted diseases</li> <li>• Medication and Dosages</li> <li>• Diagnostic Information</li> <li>• Allergies</li> <li>• Substance use history summaries</li> </ul> | <ul style="list-style-type: none"> <li>• Clinical notes</li> <li>• Discharge summary</li> <li>• Employment Information</li> <li>• Living Situation</li> <li>• Social Supports</li> <li>• Claims Encounter Data</li> <li>• Lab Tests</li> </ul> |
|---|---|--|

Health information is private and cannot be given to other people without proper permission under New York State and U.S. laws and rules. The providers that can get and see your child’s health information must obey all these laws. They cannot give your child’s information to other people unless an appropriate guardian agrees or the law says they can give the information to other people. This is true if health information is on a computer system or on paper. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The providers that use your child’s health information and the SPOA Committee must obey these laws and rules.

**Please read all the information on this form before you sign it**

**I GIVE CONSENT** for the SPOA Committee to access ALL of my child’s health information through the RHIO and/or through PSYCKES to provide my child care or manage my child’s care, to check if my child is in a health plan and what the plan covers.

**I DENY CONSENT** for the SPOA Committee to access ALL of my child’s health information through the RHIO and/or through PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

\_\_\_\_\_  
Print Name of Patient

Patient Date of Birth \_\_\_\_\_

## Children's Single Point of Access (C-SPOA) Patient Information Sharing Consent

### Details About Patient Information and the Consent Process

#### 1. How will SPOA providers use my information?

If you agree, SPOA providers will use your health information to:

- Coordinate your health care and manage your care;
- Check if you have health insurance and what it pays for; and
- Study and make health care for patients better.

The choice you make does NOT let health insurers see your information to decide whether to give you health insurance or pay your bills.

#### 2. Where does my health information come from?

Your health information comes from places and people that gave your health care or health insurance in the past. These may include hospitals, doctors, drugstores, laboratories, health plans (insurance companies), the Medicaid program, and other groups that share health information. For a list of the information available in PSYCKES, visit the PSYCKES website at [www.psyckes.org](http://www.psyckes.org) and see "About PSYCKES" or ask your treatment provider to print the list for you.

#### 3. What laws and rules cover how my health information can be shared?

These laws and regulations include New York Mental Hygiene Law Section 33.13, New York Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (which are the rules referred to as "HIPAA").

#### 4. If I agree, who can get and see my information?

The only people who can see your health information are those who you agree can get and see it, like doctors and other people who work for the SPOA and who are involved in your health care and people who work for a SPOA provider who is giving you care to help them check your health insurance or to study and make health care better for all patients.

#### 5. What if a person uses my information and I didn't agree to let them use it?

If you think a person used your information, and you did not agree to give the person your information, call one of the providers you have said can see your records, the SPOA at \_\_\_\_\_, the United States Attorney's Office at (212) 637-2800, or the NYS Office of Mental Health Customer Relations at 800-597-8481.

#### 6. How long does my consent last?

Your consent will last until the day you take back your consent, or if the SPOA stops working, or three years after the last date of service from the SPOA, whichever comes first.

#### 7. What if I change my mind later and want to take back my consent?

You can take back your consent at any time by signing a Withdrawal of Consent Form and giving it to the SPOA. You can get this form by calling \_\_\_\_\_. Note: Even if you later decide to take back your consent, providers who already have your information do not have to take it out of their records.

#### 8. How do I get a copy of this form?

You can have a copy of this form after you sign it.

**Children’s Single Point of Access Application Part 2 – to be completed by the C-SPOA with the guardian’s assistance**

Child’s Information								
Full Name (Last, First MI)								
Date of Birth			SSN					
Symptom Checklist – current and leading to referral			Never	Rarely	Sometimes	Often	Always	Unknown
Psychotic symptoms								
Attention Deficit/ Impulse Control								
Depressed Mood								
Anxiety								
Antisocial/ Unlawful Behaviors								
Alcohol/ Substance Use/ Abuse								
Self-Injurious Behaviors								
Suicidal ideation/ Threats								
Suicide Gestures/ Attempts								
Fire Setting								
Physical Aggression								
Running Away								
Sexually Inappropriate/ Aggressive Behavior								
Difficulty in Peer Interactions								
Low Self-Esteem								
Truancy								
Other (specify)								
Current Educational Placement/ Program								
<input type="checkbox"/> Regular Class in age appropriate grade	<input type="checkbox"/> Special class for students with challenging social/emotional conditions	<input type="checkbox"/> Day Treatment Program	<input type="checkbox"/> GED					
<input type="checkbox"/> Regular Class, above grade level	<input type="checkbox"/> Education, In-district program/services	<input type="checkbox"/> Part-time Vocational/ Educational	<input type="checkbox"/> Other (specify)					
<input type="checkbox"/> Regular class but behind at least one grade	<input type="checkbox"/> Home Instruction	<input type="checkbox"/> Residential School Placement	<input type="checkbox"/> Not enrolled in school					
BOCES	Home School District	Grade	Building					
Alternate School Placement								
Date of last IEP								
Committee on Special Education Classification (CSE)								
<input type="checkbox"/> Emotional Impairment	<input type="checkbox"/> Sensory impairment (vision, hearing)	<input type="checkbox"/> Other Health Impairment						
<input type="checkbox"/> Intellectual Impairment	<input type="checkbox"/> Autism	<input type="checkbox"/> Unknown						
<input type="checkbox"/> Learning Impairment	<input type="checkbox"/> Physical Impairments	<input type="checkbox"/> Other (specify)						
<input type="checkbox"/> Multiple Impairments	<input type="checkbox"/> Speech/ Language Impaired							



**Children's Single Point of Access Application Part 2 – to be completed by the C-SPOA with the guardian's assistance**

**Diagnostic Information**

Diagnosis 1.	Date of Diagnosis
2.	Name & Credentials of Person Making Diagnosis
3.	
4.	Organization
5.	Phone
Medication for a Medical Condition	
Medication for a Psychiatric Condition	

**Functional Limitation(s)**

**Moderate**

**Severe**

Functional Limitation(s)	Moderate	Severe
Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries)	<input type="checkbox"/>	<input type="checkbox"/>
Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting)	<input type="checkbox"/>	<input type="checkbox"/>
Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time)	<input type="checkbox"/>	<input type="checkbox"/>
Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability)	<input type="checkbox"/>	<input type="checkbox"/>
Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school)	<input type="checkbox"/>	<input type="checkbox"/>

**Child Strengths**

- |   |   |
|---|---|
| <input type="checkbox"/> Self-advocacy  | <input type="checkbox"/> Family support                                       |
| <input type="checkbox"/> Conflict resolution skills                           | <input type="checkbox"/> Good ability to establish rapport                    |
| <input type="checkbox"/> Sets goals/works                                     | <input type="checkbox"/> Good personal hygiene and care in appearance         |
| <input type="checkbox"/> Seeks outside assistance when needed                 | <input type="checkbox"/> Good physical health                                 |
| <input type="checkbox"/> Follows through with recommendations/addresses needs | <input type="checkbox"/> Healthy social supports/peer group                   |
| <input type="checkbox"/> Open to/accepting of service/treatment               | <input type="checkbox"/> Involvement in activities/community                  |
| <input type="checkbox"/> Capacity for openness                                | <input type="checkbox"/> Religious institution/spiritual involvement          |
| <input type="checkbox"/> Interested in relationships with others              | <input type="checkbox"/> Views self as belonging to a specific cultural group |
| <input type="checkbox"/> Capacity to tolerate painful emotions                | <input type="checkbox"/> Other (please specify) _____                         |

**Caregiver Strengths**

- |   |   |
|---|---|
| <input type="checkbox"/> Ability to appropriately monitor and discipline                      | <input type="checkbox"/> Problem-solving skills   |
| <input type="checkbox"/> Involved in seeking and supporting care to address the child's needs | <input type="checkbox"/> Ability to navigate other systems involved (e.g. legal, medical, developmental disabilities, etc.) |
| <input type="checkbox"/> Seeks additional information to advocate for the child               | <input type="checkbox"/> Maintains safe, secure environment for the child   |
| <input type="checkbox"/> Ability to organize and manage household                             | <input type="checkbox"/> Religious institution/spiritual involvement  |
| <input type="checkbox"/> Presence of natural supports to help raise child                     | <input type="checkbox"/> Views self as belonging to a specific cultural group   |
| <input type="checkbox"/> Provides stable housing  | <input type="checkbox"/> Other (please specify) _____   |
| <input type="checkbox"/> Healthy social supports/peer group                                   |   |

**Children's Single Point of Access Application Part 2 – to be completed by the C-SPOA with the guardian's assistance**

**Adverse Childhood Experiences (ACE)**

Has an ACE screening been conducted?  <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	If so, by whom? (please provide name and contact info)
If so, please provide the score:	

**Complex Trauma Screening**

<b>Prompts/Questions</b> If the answer to any question in one row is yes, please move on to the next row	<b>Present?</b> Y/N	<b>&gt; 6 mos?</b>
<ul style="list-style-type: none"> <li>• Was there a time when adults who were supposed to be taking care of the child didn't?</li> <li>• Has there ever been a time when the child did not have enough food to eat?</li> <li>• Did a parent or other adult in the household often ...                              Swear at the child, insult the child, put the child down, or humiliate the child?                              Or act in a way that made the child afraid that the child might be physically hurt?</li> </ul>	Yes  No	
<ul style="list-style-type: none"> <li>• Has the child lived with someone other than the child's parents/caregiver while the child was growing up (because they couldn't take care of the child or the child was kicked out)?</li> <li>• Has the child ever been homeless?                              ○ This means the child ran away or was kicked out and lived on the street for more than a few days? Or the child and the child's family had no place to stay and lived on the street, or in a car, or in a shelter?</li> </ul>	Yes  No	
<ul style="list-style-type: none"> <li>• Has the child lost a primary caregiver through death, incarceration, deportation, migration, or for other reasons?</li> <li>• Has the child been left in the care of different people due to parental incapacity or dysfunction, even if the child's primary place of residence did not change?</li> <li>• Has the child had two or more changes in primary caregiver or guardian, either formally (legally) or informally?</li> </ul>	Yes  No	
<ul style="list-style-type: none"> <li>• Has anyone ever made the child do sexual things the child didn't want to do, like touch the child, make the child touch them, or try to have any kind of sex with the child?</li> <li>• Has anyone ever <i>tried</i> to make the child do sexual things the child didn't want to do?</li> <li>• Has anyone ever forced the child (or tried to force the child) to have intercourse?</li> </ul>	Yes  No	
<ul style="list-style-type: none"> <li>• Has the child ever been hit or intentionally hurt by a family member?                              ○ If yes, did the child have bruises, marks or injuries?</li> </ul>	Yes  No	
<ul style="list-style-type: none"> <li>• Has the child ever <i>seen</i> or <i>heard</i> someone in the child's family/house being beaten up</li> <li>• Has the child ever <i>seen</i> or <i>heard</i> someone in the child's family/house get threatened with harm?</li> </ul>	Yes  No	
<ul style="list-style-type: none"> <li>• Has the child ever <i>seen</i> or <i>heard</i> someone being beaten, or who was badly hurt?</li> <li>• Has the child seen someone who was dead or dying, or <i>watched</i> or <i>heard</i> them being killed?</li> <li>• Has anyone ever hit anyone or beaten anyone up (physically assaulted anyone?)</li> <li>• Has anyone ever threatened to physically assault anyone (with or without a weapon)?</li> </ul>	Yes  No	
<ul style="list-style-type: none"> <li>• Did other children often tease or insult anyone, put anyone down, or threaten anyone physically?</li> <li>• Did they spread lies about anyone or turn other people against anyone?</li> </ul>	Yes  No	
<ul style="list-style-type: none"> <li>• Has anyone or anyone in the child's family been involved in, or <i>in direct danger</i> from a terrorist attack, war, or political violence?</li> </ul>	Yes  No	
<ul style="list-style-type: none"> <li>• Has anyone ever stalked the child?</li> <li>• Did anyone ever try to kidnap the child?</li> </ul>	Yes  No	
<ul style="list-style-type: none"> <li>• Is there anything else really scary or very upsetting that has happened to the child that I haven't asked about? Sometimes people have something in mind but they're not comfortable talking about the details. Is that true for you?</li> </ul>	Yes  No	

