COLUMBIA COUNTY
SINGLE POINT OF ACCESS FOR RESIDENTIAL SERVICES
AUTHORIZATION TO RELEASE INFORMATION V2015
DEPARTMENT OF HUMAN SERVICES
325 COLUMBIA STREET; HUDSON, NEW YORK 12534

Applicant's Name:_____ _____ _____
Last, First MI

Disclosure with Client Authorization

Specific information to be disclosed	
Psycho-social History	Disability Documentation
Psychiatric Assessment	Day Program Recommendation
Medical Exam including TB test and HepB Test Documentation	Financial/Insurance Information
Medicaid Authorization for Restorative Services	Functional Assessment
Homeless Eligibility Documentation	Other:
(The person authorizing this disclosure has the right to inspect and copy the disclosed information**)**	

Purpose or need for disclosure
To help determine the need/level of care for SPOA Residential Services

Name or title of person and/or organization permitted to disclose and exchange information

Name: _____

Agency/Affiliation: _____

Address: _____

Phone: _____

Information will be disclosed and exchanged with:
The Single Point Team which includes personnel from: **Columbia County Department of Human Services/Mental Health Center, Columbia Memorial Hospital, Mental Health Association of Columbia & Greene Counties, Newman's Residence, Philmont Hearth, Twin Counties Recovery Services, St. Catherine's, Columbia County Department of Social Services.**

I understand, by signing this release, I am permitting the above indicated organizations to disclose and exchange confidential information for the purpose of coordinating residential services. I understand that this authorization can be withdrawn by me, in writing*, at any time except to the extent that action has been taken in reliance upon it. I further understand that signing this document does not affect protections under state or federal confidentiality law in reference to Part 2 Title 42 of the code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records which states that re-disclosure of this information and/or documentation to any party other than those designated is forbidden without my further written authorization. I understand this release will automatically expire one year from date signed.

***see reverse side to revoke authorization**

_____ _____
Client Signature Date

_____ _____
Witness Date

** You have the right to refuse to sign this authorization

Cancellation/Refusal to Release Information	
☐ I hereby cancel my authorization to release information to The Single Point of Access (SPOA) for Residential Services.	☐ I hereby refuse to authorize the release of information to The Single Point of Access (SPOA) for Residential Services

Applicant Signature _____ Date _____

Signature of witness _____ Date _____