NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

INFORMED CONSENT FOR THE OFFICE OF MENTAL HEALTH RESIDENTIAL TREATMENT FACILITY AUTHORIZATION REVIEW PROCESS

Youth's Name (Last) (First) (M.I.)	Youth's Date of Birth
Youth's Address	
Referring Source Name	
Referring Source Address	

I, or my authorized representative, request that health information regarding the above-named youth's care and treatment be released as set forth on this form. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- A specific authorization is required to use or disclose drug or alcohol diagnoses or treatment information or confidential HIV related information.
- I have the right to know what information about the youth has been shared, and why, when, and with whom it was shared.
- I have the right to cancel my authorization to release information by notifying the referring agency or the OMH RTF Authorization Coordinator in writing, or to withdraw from the OMH RTF Authorization Review Process any time before it is released. This will stop OMH from sharing information after my consent has been withdrawn.
- I also understand that the OMH RTF Authorization Review Process may be composed of reviewers from the following agencies:
  Office of Mental Health (OMH) Office of Children and Family Services (OCFS) State Education Department (SED)
  Children-Single Point of Access (C-SPOA) Office for People with Developmental Disabilities (OPWDD)
- I authorize the release of clinical and educational information to OMH regarding the above-named youth. I understand that the OMH RTF Authorization Review Process will review and evaluate this information to determine the youth's medical necessity for authorization to apply for admission to RTF(s) and will maintain the confidentiality of this information. I understand that the information will be shared in written form, in meetings, by phone or by computerized data.
- I authorize the OMH RTF Authorization Coordinator(s) to release the above information to RTF(s). I understand that this information will be used to evaluate the youth for possible admission to the RTF(s) and that the RTF(s) will maintain the confidentiality of this information.
- Should the OMH grant authorization to apply for admission to an RTF(s) to the above-named youth, I authorize OMH to release the above information to the youth's **School District of Residence** _____ _____ **Committee on Special Education(CSE)**, to request that the CSE evaluate the youth. I authorize OMH to then obtain the CSE evaluation and written recommendations for appropriate educational services while the youth is attending an RTF (SED Law Article 81 § 4005.1.d-e.) If the youth is in the hospital at the time of referral the school district of residence shall be the school district of residence at the time he or she entered the hospital.
- This consent to release information will expire: a) six months from the signed date if the youth is not

admitted into an RTF or b) when the youth is discharged from an RTF.

This authorization must be completed by the parent/legal guardian and youth where appropriate to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and HIPAA). The federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and/or HIPAA. **A general authorization for the release of medical or other information is NOT sufficient for this purpose.** The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____
Signature of Youth (where appropriate and available)

_____ _____
Signature of Parent/Legal Guardian Relationship

_____ _____
Print Name Signed Date Signed

_____ _____
Signature of Witness Title

_____ _____
Print Name Signed Date Signed

_____ _____
Signature of Person Completing Form (If different from Parent/Guardian) Title

_____ _____
Print Name Signed Date Signed

FOR OMH USE ONLY

CONSENT HAS BEEN:

- ☐ Revoked in entirety
- ☐ Partially revoked as follows:
- ☐ Letter (Attach Copy)

DATE REQUEST RECEIVED:_____

OMH REPRESENTATIVE RECEIVING REQUEST:

_____
(OMH REPRESENTATIVE'S FULL NAME AND TITLE)

Revised 06/2020