

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

Youth Applicant's Name	(Last)	(First)	(M.I.)	Youth's Date of Birth
Youth's Permanent Addre	ss			
Referring Source Name				
Referring Source Address	3			

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 Office of Mental Health (OMH) Residential Treatment Facility (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 This will stop OMH from sharing information after my consent has been withdrawn.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 youth's local Children-Single Point of Access (C-SPOA) and Office of Mental Health (OMH.) As applicable, reviewers may also include representatives from the Office for People with Developmental Disabilities (OPWDD), Office of Children and Family Services (OCFS), and State Education Department (SED.)
- 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 eligibility and 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.
- This consent to release information will expire: a) one year 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 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.



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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 Parent Relationship Print Name Signed **Date Signed** Signature of Legal Guardian \* Title Print Name Signed Date Signed \*Legal documentation indicating authority to sign in lieu of parent(s) listed on birth certificate must be submitted with this Signature of Witness Title **Print Name Signed Date Signed** FOR OMH USE ONLY CONSENT HAS BEEN: Revoked in entirety Partially revoked as follows: Letter (Attach Copy) OMH REPRESENTATIVE RECEIVING REQUEST: DATE REQUEST RECEIVED: (OMH REPRESENTATIVE'S FULL NAME AND TITLE)



## REQUEST FOR DISABILITY DETERMINATION

Name of Youth Applicant:	
Youth's Date of Birth:	
This is to request that the Office of Mental Health (OMH) do youth applicant is disabled for the purposes of the Medica by the Department of Social Services.	
authorize OMH to review and evaluate any mental health, has received to assess whether the above-named youth is request clarification or obtain additional documentation ne nformation to determine whether he/she is disabled.	disabled. I also authorize OMH to
understand that this form is not an application or reapplication or reapplication or reapplication or reapplication or reapplication, and that OMH will be determining whether the abwhether he/she is eligible for Medical Assistance.	
	Signature of Parent/Legal Guardian
	Relationship to Applicant