Creating Hope Transforming Lives
Catholic Charities
DIOCESE OF SYRACUSE
Oswego County

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name (Last, First, M.I.) | Date of Birth:

Staff Person Name: | Program Name:

Catholic Charities of Oswego County

Facility Name

This authorization must be completed by the client or his/her personal representative to use/disclose protected health information (for other than treatment, payment, or health care operations purposes), in accordance with State and Federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed:

☐ Contact Information ☐ Current Medications ☐ Current Services ☐ Daily Living Skills ☐ Diagnosis
☐ Education ☐ Entitlements ☐ Emergency Contact Info. ☐ Functional Abilities ☐ Mental Health Status
☐ : _____

Info can be disclosed:

☐ Verbal
☐ Written

Purpose or Need for Information:

1. This information is being requested:
   ☐ by the individual or his/her personal representative; or
   ☐ Other (please describe) Catholic Charities (Oswego County)
2. The purpose of the disclosure is (please describe)

☐ Assessment ☐ Bill Insurance ☐ Emergency Contact ☐ Emergency Services
☐ Establish Entitlements ☐ Establish Services ☐ Housing ☐ Skill Development
☐ Treatment Coordination
☐ OTHER: _____

Exchange of Information between the parties below
(Include: Name, Address, Title of person/Organization/Facility/Program)

Catholic Charities (Oswego County)
808 W. Broadway Street
Fulton, NY 13069
Phone #: (315) 598-3980
Fax #: (315) 593-8440

Organization Name/Address/Phone #1:

Organization Name/Address/Phone #2:

Organization Name/Address/Phone #3:

Organization Name/Address/Phone #4:

Organization Name/Address/Phone #5:

Emergency Contact Name/Address/Phone:

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by Catholic Charities shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain services from the Catholic Charities of Oswego County, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524).

Facility/Agency Name	Client's Name (Last, First, M.I.)
Catholic Charities (Oswego County)	

B. Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above between the person(s)/organization(s)/facility(s)/program(s) identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

- ☐ When I am no longer receiving services from:
- ☐ One year from this date
- ☐ Other: _____

- ☐ AMP
- ☐ CFTSS
- ☐ Parent Education
- ☐ Drop-In
- ☐ CYO
- ☐ Care Management

- ☐ HCBS
- ☐ Emergency Services
- ☐ Community Services
- ☐ Mental Health Transportation
- ☐ DSS Services Transportation
- ☐ Visitation

C. Client Signature: I certify that I authorize the use of my health information as set forth in this document.

Signature of Client or Personal Representative _____ Date _____

Client's Name (Printed) _____

Personal Representative's Name (Printed) _____

Description of Personal Representative's Authority to Act for the Client(*required if Personal Representative signs Authorization)* _____

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the client and/or the client's personal representative.

WITNESSED BY: _____
Staff person's name and title

Authorization Provided to: Catholic Charities (Oswego County)

Date: _____

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part 1, between the Person(s)/Organization(s)/Facility(s)/Program(s) whose name and address is:

_____

_____

_____

I hereby refuse to authorize the use/disclosure indicated in Part 1, between the Person(s)/Organization(s)/Facility(s)/Program(s) whose name and address is:

_____

_____

_____

Signature of Client or Personal Representative _____ Date _____

Client's Name (Printed) _____

Personal Representative's Name (Printed) _____

Description of Personal Representative's Authority to Act for the Client *(required if Personal Representative signs Revocation of Authorization)* _____