NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

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 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 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 This will stop OMH from sharing information after my consent has been withdrawn.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 form.

_____ _____
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)

DATE REQUEST RECEIVED:_____

OMH REPRESENTATIVE RECEIVING REQUEST:

(OMH REPRESENTATIVE'S FULL NAME AND TITLE)

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

REQUEST FOR DISABILITY DETERMINATION

Name of Youth Applicant: _____

Youth's Date of Birth: _____

This is to request that the Office of Mental Health (OMH) determine whether the above-named youth applicant is disabled for the purposes of the Medical Assistance Program, as designated by the Department of Social Services.

I authorize OMH to review and evaluate any mental health, health, or educational information it has received to assess whether the above-named youth is disabled. I also authorize OMH to request clarification or obtain additional documentation necessary to confirm or verify this information to determine whether he/she is disabled.

I understand that this form is not an application or reapplication for Medical Assistance benefits, and that OMH will be determining whether the above-named youth is disabled but not whether he/she is eligible for Medical Assistance.

_____

Signature of Parent/Legal Guardian

_____

Relationship to Applicant

_____

Date Signed