Broome County

Adult Single Point of Access

(A-SPOA)

Instructions

for

Universal Consent for Release of Information

This document provides item-by-item descriptions of information needed to successfully complete the Adult *Universal Consent for Release of Information.*

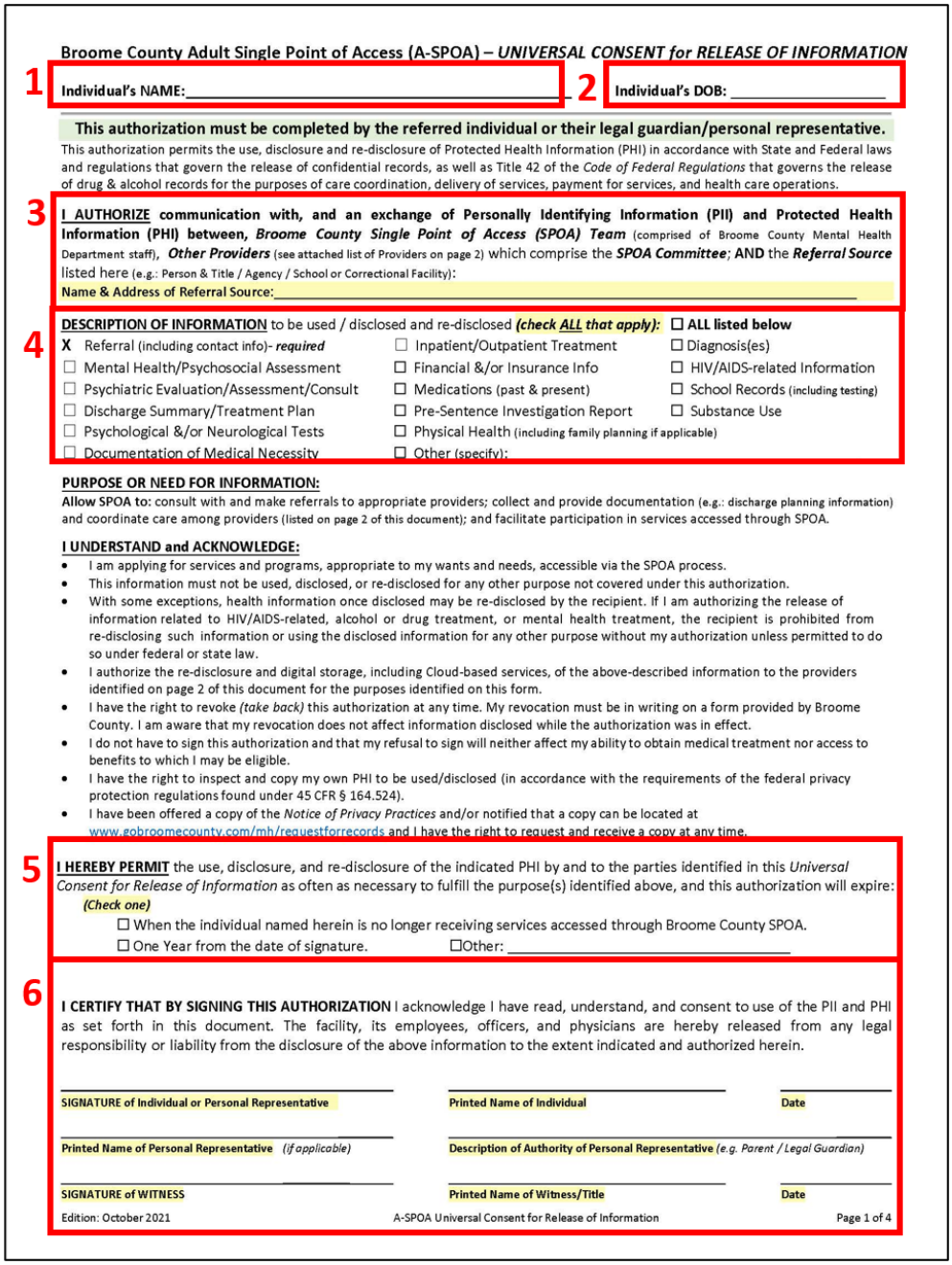
This document is best suited for *Adobe Acrobat Reader*.

Download here: https://get.adobe.com/reader/

Use TAB button to toggle forward through Application. Use SHIFT + TAB to toggle backwards.

For the ***Universal Consent for Release of Information*** to be valid, items boxed in **RED** need to be completed.

1	Enter the Applicant's First and Last Name.
2	Enter the Applicant's Date of Birth (MM/DD/YYYY).
3	Enter Name of Referral Source
4	Select the boxes, to the left of the description, of the information to be disclosed.
5	Select the box next to the time frame you wish the Consent to be valid. • If other, please enter the date you wish the Consent to expire.
6	Individual must date, print and sign their name as the applicant.



Broome County Adult Single Point of Access (A-SPOA) – *UNIVERSAL CONSENT for RELEASE OF INFORMATION*

1 **Individual's NAME:**_____ **2** **Individual's DOB:** _____

This authorization must be completed by the referred individual or their legal guardian/personal representative.

This authorization permits the use, disclosure and re-disclosure of Protected Health Information (PHI) in accordance with State and Federal laws and regulations that govern the release of confidential records, as well as Title 42 of the *Code of Federal Regulations* that governs the release of drug & alcohol records for the purposes of care coordination, delivery of services, payment for services, and health care operations.

3 **I AUTHORIZE communication with, and an exchange of Personally Identifying Information (PII) and Protected Health Information (PHI) between, *Broome County Single Point of Access (SPOA) Team*** (comprised of Broome County Mental Health Department staff), ***Other Providers*** (see attached list of Providers on page 2) which comprise the ***SPOA Committee***; **AND** the ***Referral Source*** listed here (e.g.: Person & Title / Agency / School or Correctional Facility):

Name & Address of Referral Source:_____

4 **DESCRIPTION OF INFORMATION** to be used / disclosed and re-disclosed ***(check ALL that apply):***

☐ **ALL listed below**		
X Referral (including contact info)- ***required***	☐ Inpatient/Outpatient Treatment	☐ Diagnosis(es)
☐ Mental Health/Psychosocial Assessment	☐ Financial &/or Insurance Info	☐ HIV/AIDS-related Information
☐ Psychiatric Evaluation/Assessment/Consult	☐ Medications (past & present)	☐ School Records (including testing)
☐ Discharge Summary/Treatment Plan	☐ Pre-Sentence Investigation Report	☐ Substance Use
☐ Psychological &/or Neurological Tests	☐ Physical Health (including family planning if applicable)	
☐ Documentation of Medical Necessity	☐ Other (specify):	

PURPOSE OR NEED FOR INFORMATION:

Allow SPOA to: consult with and make referrals to appropriate providers; collect and provide documentation (e.g.: discharge planning information) and coordinate care among providers (listed on page 2 of this document); and facilitate participation in services accessed through SPOA.

I UNDERSTAND and ACKNOWLEDGE:

- I am applying for services and programs, appropriate to my wants and needs, accessible via the SPOA process.
- This information must not be used, disclosed, or re-disclosed for any other purpose not covered under this authorization.
- With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of information related to HIV/AIDS-related, alcohol or drug treatment, or mental health treatment, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law.
- I authorize the re-disclosure and digital storage, including Cloud-based services, of the above-described information to the providers identified on page 2 of this document for the purposes identified on this form.
- I have the right to revoke *(take back)* this authorization at any time. My revocation must be in writing on a form provided by Broome County. I am aware that my revocation does not affect information disclosed while the authorization was in effect.
- I do not have to sign this authorization and that my refusal to sign will neither affect my ability to obtain medical treatment nor access to benefits to which I may be eligible.
- I have the right to inspect and copy my own PHI to be used/disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR § 164.524).
- I have been offered a copy of the *Notice of Privacy Practices* and/or notified that a copy can be located at www.gobroomecounty.com/mh/requestforrecords and I have the right to request and receive a copy at any time.

5 **I HEREBY PERMIT** the use, disclosure, and re-disclosure of the indicated PHI by and to the parties identified in this *Universal Consent for Release of Information* as often as necessary to fulfill the purpose(s) identified above, and this authorization will expire:

(Check one)

☐ When the individual named herein is no longer receiving services accessed through Broome County SPOA.

☐ One Year from the date of signature. ☐Other: _____

6 **I CERTIFY THAT BY SIGNING THIS AUTHORIZATION** I acknowledge I have read, understand, and consent to use of the PII and PHI as set forth in this document. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability from the disclosure of the above information to the extent indicated and authorized herein.

SIGNATURE of Individual or Personal Representative _____ **Printed Name of Individual** _____ **Date** _____

Printed Name of Personal Representative *(if applicable)* _____ **Description of Authority of Personal Representative** *(e.g. Parent / Legal Guardian)* _____

SIGNATURE of WITNESS _____ **Printed Name of Witness/Title** _____ **Date** _____

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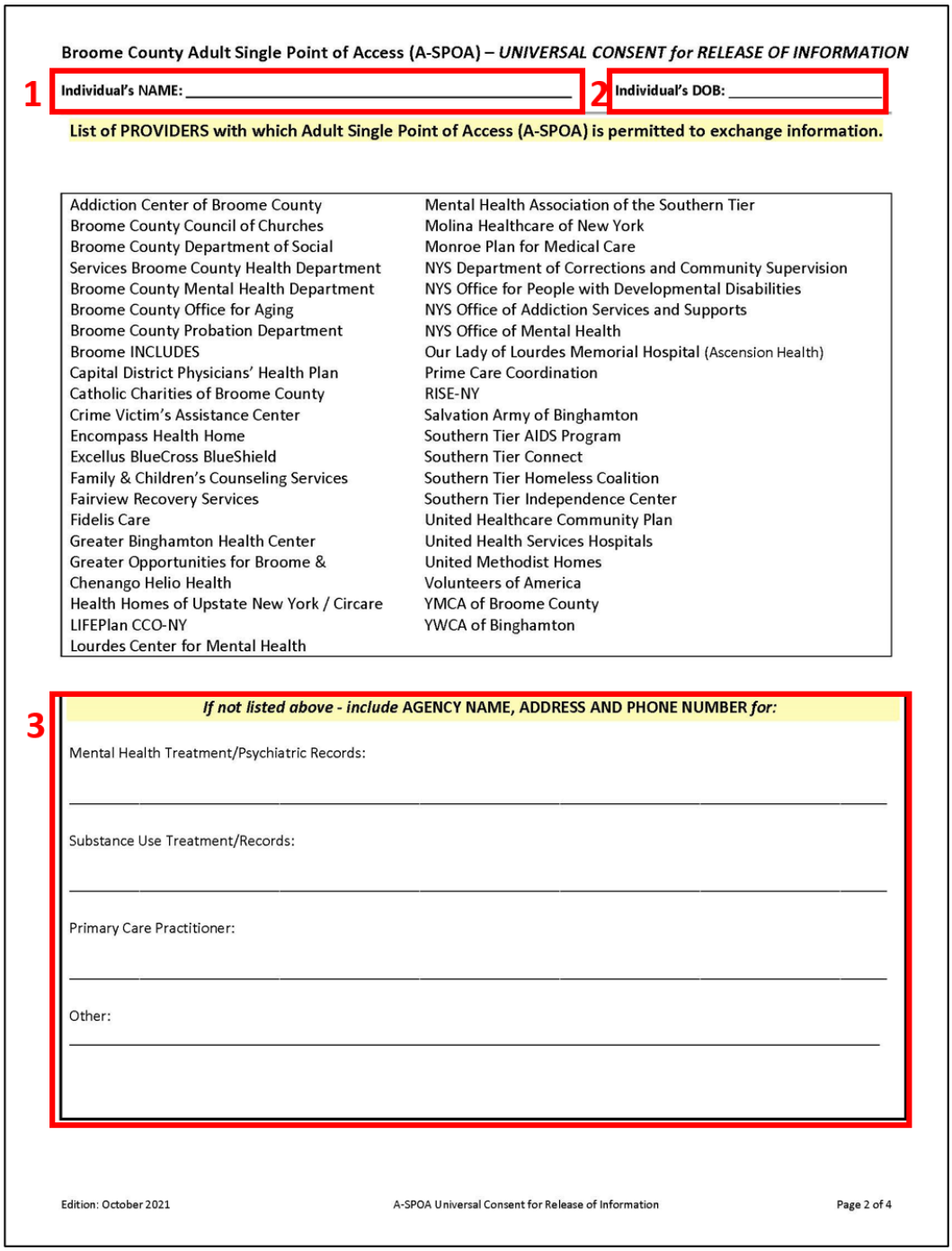
For the ***Universal Consent for Release of Information*** to be valid, items boxed in **RED** need to be completed.

1	Enter the Applicant's first and last name.
2	Enter the Applicant's Date of Birth (MM/DD/YYYY).
3	Type or Print any Providers (mental health, substance use, primary care), Individuals, or Agencies involved in the care of the individual pertinent to this application. • This can include family, friends, or other supportive individuals in the person's life.



Broome County Adult Single Point of Access (A-SPOA) – *UNIVERSAL CONSENT for RELEASE OF INFORMATION*

1 **Individual's NAME:** _____ **2** **Individual's DOB:** _____

List of PROVIDERS with which Adult Single Point of Access (A-SPOA) is permitted to exchange information.

Addiction Center of Broome County	Mental Health Association of the Southern Tier
Broome County Council of Churches	Molina Healthcare of New York
Broome County Department of Social	Monroe Plan for Medical Care
Services Broome County Health Department	NYS Department of Corrections and Community Supervision
Broome County Mental Health Department	NYS Office for People with Developmental Disabilities
Broome County Office for Aging	NYS Office of Addiction Services and Supports
Broome County Probation Department	NYS Office of Mental Health
Broome INCLUDES	Our Lady of Lourdes Memorial Hospital (Ascension Health)
Capital District Physicians' Health Plan	Prime Care Coordination
Catholic Charities of Broome County	RISE-NY
Crime Victim's Assistance Center	Salvation Army of Binghamton
Encompass Health Home	Southern Tier AIDS Program
Excellus BlueCross BlueShield	Southern Tier Connect
Family & Children's Counseling Services	Southern Tier Homeless Coalition
Fairview Recovery Services	Southern Tier Independence Center
Fidelis Care	United Healthcare Community Plan
Greater Binghamton Health Center	United Health Services Hospitals
Greater Opportunities for Broome &	United Methodist Homes
Chenango Helio Health	Volunteers of America
Health Homes of Upstate New York / Circare	YMCA of Broome County
LIFEPlan CCO-NY	YWCA of Binghamton
Lourdes Center for Mental Health	

3 ***If not listed above - include* AGENCY NAME, ADDRESS AND PHONE NUMBER *for:***

Mental Health Treatment/Psychiatric Records:

_____

Substance Use Treatment/Records:

_____

Primary Care Practitioner:

_____

Other:

_____

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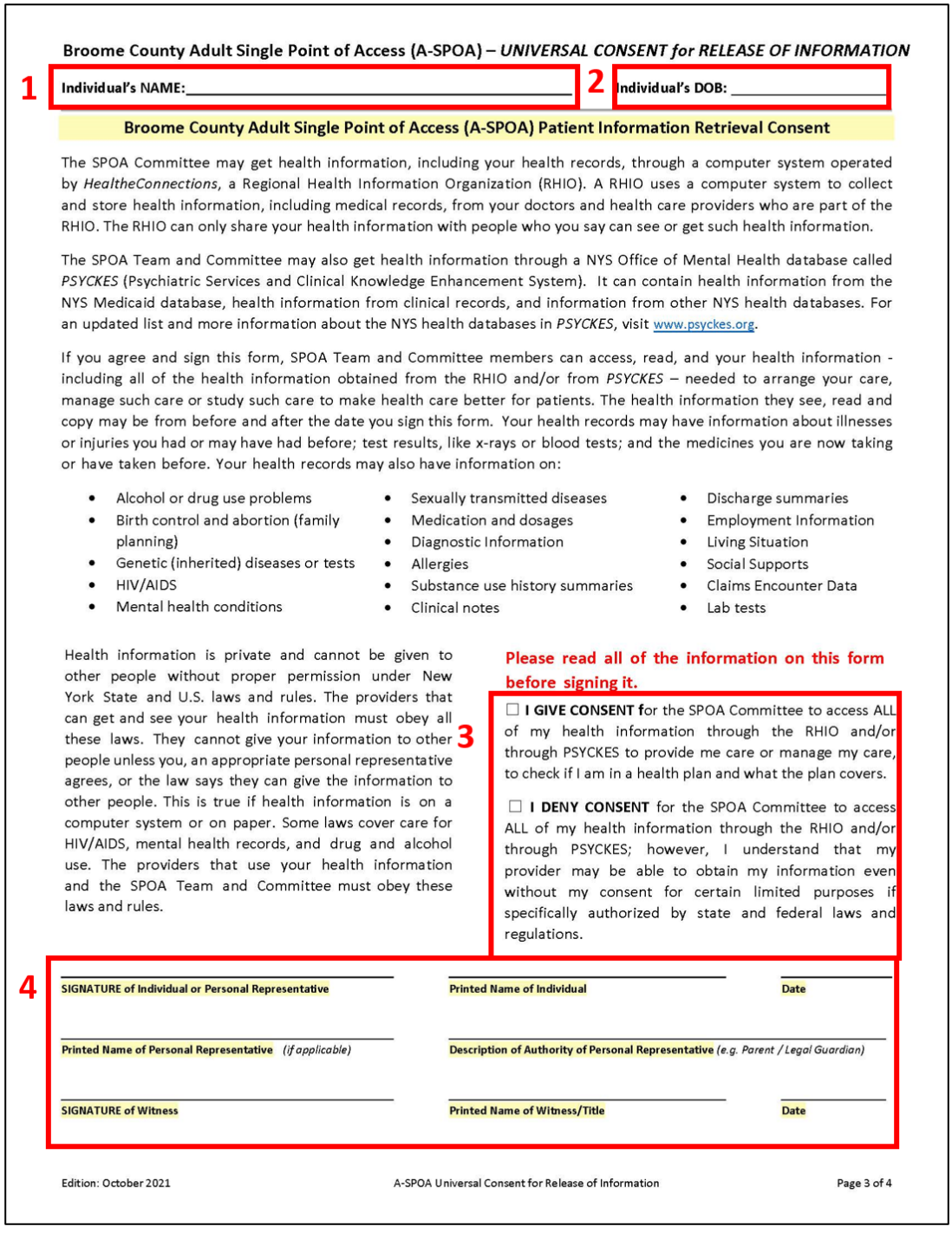
For the ***Universal Consent for Release of Information*** to be valid, items boxed in **RED** need to be completed.

1	Enter the Applicant's first and last name.
2	Enter the Applicant's Date of Birth (MM/DD/YYYY).
3	Check the box next to "I GIVE CONSENT" if giving permission to access health information via portals. Otherwise select "I DENY CONSENT".
4	Individual must date, print and sign their name as the applicant.



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1 **Individual's NAME:**_____ 2 **Individual's DOB:** _____

Broome County Adult Single Point of Access (A-SPOA) Patient Information Retrieval Consent

The SPOA Committee may get health information, including your health records, through a computer system operated by *HealtheConnections*, a Regional Health Information Organization (RHIO). A RHIO uses a computer system to collect and store health information, including medical records, from your doctors and health care providers who are part of the RHIO. The RHIO can only share your health information with people who you say can see or get such health information.

The SPOA Team and Committee may also get health information through a NYS Office of Mental Health database called *PSYCKES* (Psychiatric Services and Clinical Knowledge Enhancement System). It can contain health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in *PSYCKES*, visit www.psyckes.org.

If you agree and sign this form, SPOA Team and Committee members can access, read, and your health information - including all of the health information obtained from the RHIO and/or from *PSYCKES* – needed to arrange your care, manage such care or study such care to make health care better for patients. The health information they see, read and copy may be from before and after the date you sign this form. Your health records may have information about illnesses or injuries you had or may have had before; test results, like x-rays or blood tests; and the medicines you are now taking or have taken before. Your health records may also have information on:

- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases
- Medication and dosages
- Diagnostic Information
- Allergies
- Substance use history summaries
- Clinical notes
- Discharge summaries
- Employment Information
- Living Situation
- Social Supports
- Claims Encounter Data
- Lab tests

Health information is private and cannot be given to other people without proper permission under New York State and U.S. laws and rules. The providers that can get and see your health information must obey all these laws. They cannot give your information to other people unless you, an appropriate personal representative agrees, or the law says they can give the information to other people. This is true if health information is on a computer system or on paper. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The providers that use your health information and the SPOA Team and Committee must obey these laws and rules.

Please read all of the information on this form before signing it.

3 ☐ **I GIVE CONSENT f**or the SPOA Committee to access ALL of my health information through the RHIO and/or through PSYCKES to provide me care or manage my care, to check if I am in a health plan and what the plan covers.

☐ **I DENY CONSENT** for the SPOA Committee to access ALL of my health information through the RHIO and/or through PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

4 **SIGNATURE of Individual or Personal Representative** | **Printed Name of Individual** | **Date**

Printed Name of Personal Representative *(if applicable)* | **Description of Authority of Personal Representative** *(e.g. Parent / Legal Guardian)*

SIGNATURE of Witness | **Printed Name of Witness/Title** | **Date**

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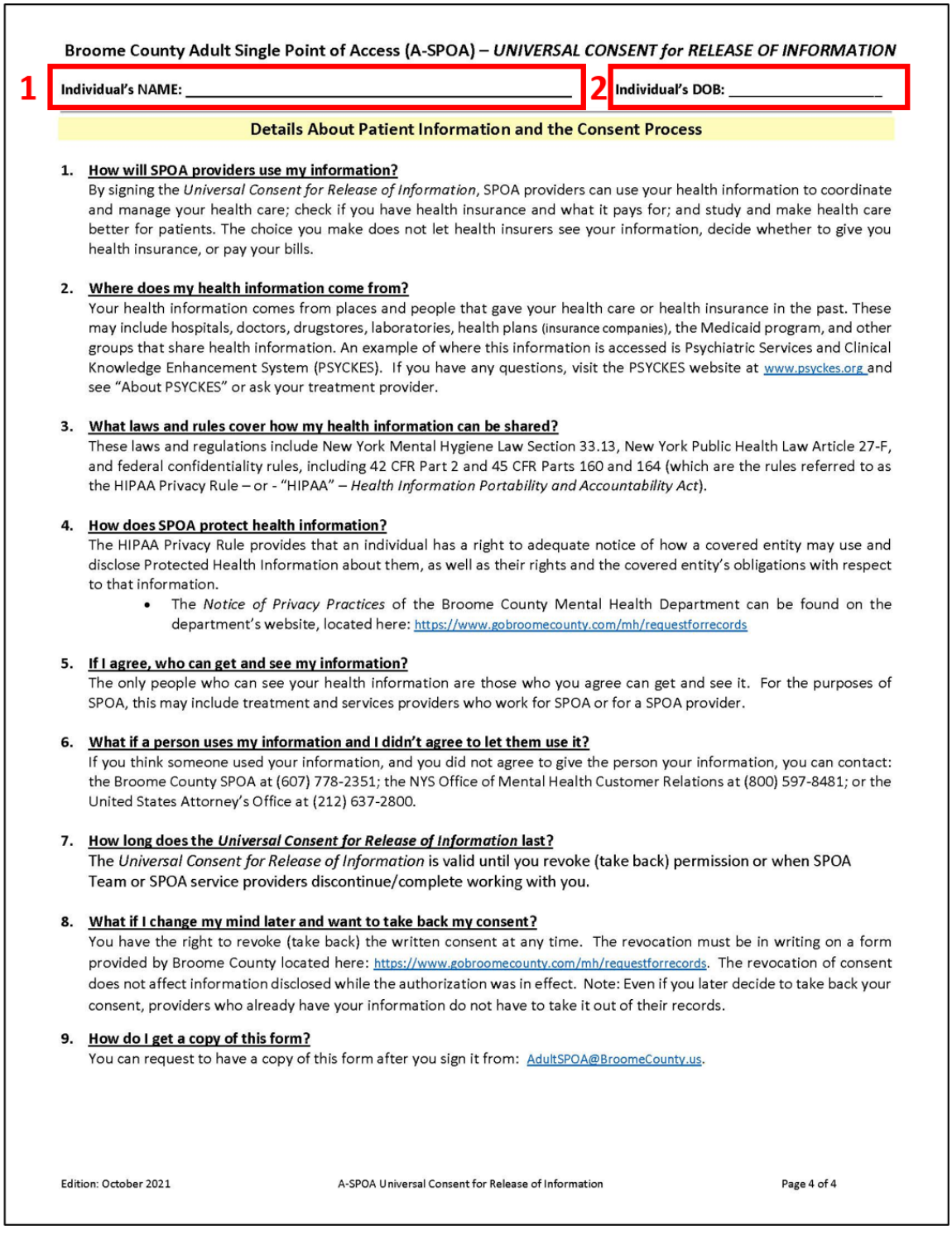
For the ***Universal Consent for Release of Information*** to be valid, items boxed in **RED** need to be completed.

1	Enter the Applicant's first and last name.
2	Enter the Applicant's Date of Birth (MM/DD/YYYY).



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1 **Individual's NAME:** _____ **2** **Individual's DOB:** _____

Details About Patient Information and the Consent Process

1. **How will SPOA providers use my information?**
   By signing the *Universal Consent for Release of Information*, SPOA providers can use your health information to coordinate and manage your health care; check if you have health insurance and what it pays for; and study and make health care better for patients. The choice you make does not let health insurers see your information, decide whether to give you health insurance, or pay your bills.

2. **Where does my health information come from?**
   Your health information comes from places and people that gave your health care or health insurance in the past. These may include hospitals, doctors, drugstores, laboratories, health plans (insurance companies), the Medicaid program, and other groups that share health information. An example of where this information is accessed is Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES). If you have any questions, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider.

3. **What laws and rules cover how my health information can be shared?**
   These laws and regulations include New York Mental Hygiene Law Section 33.13, New York Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (which are the rules referred to as the HIPAA Privacy Rule – or - "HIPAA" – *Health Information Portability and Accountability Act*).

4. **How does SPOA protect health information?**
   The HIPAA Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose Protected Health Information about them, as well as their rights and the covered entity's obligations with respect to that information.
   - The *Notice of Privacy Practices* of the Broome County Mental Health Department can be found on the department's website, located here: https://www.gobroomecounty.com/mh/requestforrecords

5. **If I agree, who can get and see my information?**
   The only people who can see your health information are those who you agree can get and see it. For the purposes of SPOA, this may include treatment and services providers who work for SPOA or for a SPOA provider.

6. **What if a person uses my information and I didn't agree to let them use it?**
   If you think someone used your information, and you did not agree to give the person your information, you can contact: the Broome County SPOA at (607) 778-2351; the NYS Office of Mental Health Customer Relations at (800) 597-8481; or the United States Attorney's Office at (212) 637-2800.

7. **How long does the *Universal Consent for Release of Information* last?**
   The *Universal Consent for Release of Information* is valid until you revoke (take back) permission or when SPOA Team or SPOA service providers discontinue/complete working with you.

8. **What if I change my mind later and want to take back my consent?**
   You have the right to revoke (take back) the written consent at any time. The revocation must be in writing on a form provided by Broome County located here: https://www.gobroomecounty.com/mh/requestforrecords. The revocation of consent does not affect information disclosed while the authorization was in effect. Note: Even if you later decide to take back your consent, providers who already have your information do not have to take it out of their records.

9. **How do I get a copy of this form?**
   You can request to have a copy of this form after you sign it from: AdultSPOA@BroomeCounty.us.

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