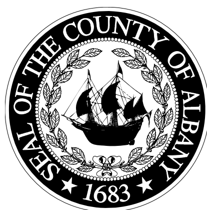

DANIEL P. MCCOY
COUNTY EXECUTIVE

COUNTY OF ALBANY
DEPARTMENT FOR CHILDREN, YOUTH AND FAMILIES
112 STATE STREET – SUITE 300
ALBANY, NEW YORK 12207
(518) 447-4820 - FAX (518) 447-4855
www.albanycounty.com

GAIL GEOHAGEN-PRATT
COMMISSIONER

MOIRA E. MANNING
DEPUTY COMMISSIONER

DIVISION FOR CHILDREN WITH SPECIAL NEEDS
COMPREHENSIVE EVALUATION SERVICES
PERMISSION TO RELEASE INFORMATION

This is a voluntary release of records. If you do not want your child's records released, you do not need to fill out this form.

Child's Name: ____

DOB: ________/________/________ Gender: ☐ Male ☐ Female

I hereby authorize the use and/or disclosure of my protected health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider or health care clearinghouse, the released information may no longer be protected by federal privacy regulations, except that a recipient may be prohibited from redisclosing substance abuse information under the federal substance abuse confidentiality requirements. State law governs the release of HIV/AIDS information and you may request a list of persons authorized to re-release HIV/AIDS related information. Release of information relating to minors may also be protected by additional state and/or federal regulations.

- Persons/Organizations receiving the information: (your child's physician's name, address & phone number and other persons/organizations that you designate to receive this information)

  ____

  ____

- Persons/Organizations providing the information:

  Albany County Department for Children, Youth and Families, Division for Children with Special Needs Comprehensive Evaluation Services, 112 State Street, Suite 300 Albany NY 12207

  ____

- Description of the information to be released (A request for the entire record must be accompanied by an explanation why the entire record is needed):

  Evaluation Report

  Written Summary

  ____

- Purpose for release:

  To provide a copy of your child's evaluation report to his/her pediatrician. This is voluntary and not required.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment, except as permitted by law.

I may inspect or copy any information to be used and/or disclosed under this authorization, as provided for in the regulations.

Unless action has been taken in reliance upon this authorization, I may revoke it at any time, provided that I do so in writing. An explanation of how to revoke this authorization may be found in Paragraph 3 of the County's *Notice of Privacy Practices*.

This authorization shall be in force and effect until: (enter the date of your child's fifth birthday)

____

Date or event that relates to the individual who is the subject of the PHI or the purpose of the use or disclosure at which time this authorization to use, disclose or obtain this protected health information expires.

Parent's Signature (Parent, Legal Guardian or Legal Representative)	Date
Address	Telephone #
Print Name	
Relationship to Child	
Authorized Albany County Department Staff Signature	Date

A copy of this signed form will be provided to the individual or legal guardian.

HIV/AIDS specific information:

For questions/complaints regarding HIV/AIDS discrimination, call the New York State Division of Human Rights at (518) 474-2705 or the New York City Commission on Human Rights at (212) 306-7450.

Federally protected substance abuse information:

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it.

New York State Mental Hygiene information:

I understand that my records are protected under the New York State Mental Hygiene Law section 33.13 and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it.