NYS Office of Alcoholism and Substance Abuse Services
Authorization for Release of Behavioral Health Information – OASAS Client Data System

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment may be released and exchanged as set forth on this form. I understand that:

1. This authorization may include disclosure of all of my health information, including where applicable, my federal social security number (for record matching purposes only), any and all information relating to ALCOHOL and DRUG TREATMENT and HIV/AIDS-RELATED information. In the event the health information described below includes any of these types of information I specifically authorize release of such information to the New York State Office of Alcoholism and Substance Abuse Services (OASAS).

   _____ If you initial this line, HIV-AIDS RELATED information can also be released to OASAS. You do not have to initial this line.

   _____ If you initial this line, your Social Security Number can also be released to OASAS. You do not have to initial this line.

2. With some exceptions, health information once disclosed may be redisclosed by the receiving entity. If I am authorizing the release of my federal social security number, HIV/AIDS-related, alcohol or drug treatment, the receiving entity is prohibited from redisclosing such information or using the disclosed information for any purpose other than the purpose indicated by this authorization without my further authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity Releasing and Exchanging this Information:

6. Name and Address of Entities to whom this Information will be Disclosed and Exchanged:

   NYS Office of Alcoholism and Substance Abuse Services, 1450 Western Avenue, Albany, New York 12203

   I authorize the above listed Entity to inform the New York State Office of Alcoholism and Substance Abuse Services (OASAS) of my enrollment in this treatment program so that the quality of the services I receive may be evaluated, I also consent to all necessary communications between this facility and OASAS relative to my past alcohol and/or substance abuse treatment history; current and proposed treatment services.

7. The Purpose of this disclosure is to comply with implemention of New York's Medicaid redesign initiative and to comply with mandatory federal reporting requirements. By accepting the information covered by this consent into the NYS OASAS Client Data System, NYS OASAS acknowledges that this information may not be redisclosed per 42 CFR 2.32 - Prohibition on redisclosure.

8. My health information may be disclosed for a period of three (3) years from last the date of service, or until revoked.

9. If not the patient , name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

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

_____ _____ _____
STAFF PERSON'S NAME AND TITLE SIGNATURE DATE

Alcohol/drug treatment related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.