NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT TO RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

Revoked On:_____ Staff Initials:_____

Patient's Last Name	First	M.I.
Case Number		
Facility	Unit	

INSTRUCTIONS: GIVE A COPY OF THIS FORM TO PATIENT! Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED

All information necessary to investigate any alleged incident(s) of abuse or neglect, or other significant incidents, in which I may be named or am otherwise relevant.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION.

1) I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS) including its Bureau of Special Hearings, and the NYS Justice Center for the Protection of People with Special Needs (JC) including its Vulnerable Persons Central Register (VPCR) for the purpose of investigating or making determinations regarding any alleged incident(s) of abuse or neglect, or other significant incidents, in which I might be named or am otherwise relevant.

2) If I am a minor (under 18), I additionally consent to this program, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS) and the Justice Center for the Protection of Vulnerable Persons (JC) providing notification to my parent or legal guardian regarding any alleged incident(s) of abuse or neglect, or other significant incidents, in which I might be named or am otherwise relevant.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose and obtain such information as herein specified. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

Time period, event or condition extending period specified above: Completion of an investigation by the Justice Center into an allegation of abuse or neglect, or other significant incident, pursuant to Chapter 501 of the Laws of 2012 and determination of a proceeding under NY Social Services Law Article 6, title 6.

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NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____ (Signature of Patient)

_____ (Signature of Parent/Guardian)

_____ (Print Name of Patient)

_____ (Print Name of Parent/Guardian)

_____ (Date)

_____ (Date)