NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES

AOT PROGRAM APPLICATION

APPLICATION GUIDE

- **FOR Assisted Outpatient Treatment (AOT) Program,** please refer to the following pages: 2 - 9. **Pages 4 - 8 must be fully completed and submitted for review.**

    - **Page 2:** AOT Cover Letter explaining application requirements
    - **Page 3:** AOT Program Description
    - **Pages 4 – 6**: AOT Eligibility Form and Application
    - **Pages 7- 8:** AOT Consent Form
    - **Page 9 - 10:** AOT Family / Collateral Contact Consent Form **(*optional but encouraged)***

AOT PROGRAM APPLICATION

Dear Sir/Madam and/or Referral Source,

Thank you for your interest in the Niagara County Department of Mental Health Assisted Outpatient Treatment (AOT) / Kendra's Law Program. Following this page you will find information on AOT criteria for referral, description of services, and application for services.

If you are the person requesting personal services and completing the application, please do your best to complete all sections. If you are uncertain of the diagnostic section, you may leave this blank, but be sure on the consent form to write in your mental health counselor's, therapist's, doctor's and/or psychiatrist's name and/or agency you attend, or have attended in the past, so we may obtain this information.

For other **referral sources**, please complete ***all*** applicable sections of the application (see application guide on cover of this packet). Please ensure to do all of the following:

- **Write legibly**.
- Place a **line through or write "N/A" in spaces that are not relevant**. ***Do not leave lines/sections just blank***.
- **Write in all information**—***do not write "see attached"*** as others who have authorization to review the application may not have all of the attached documentation to review.

- **Attach the following**:
  - **Supporting documentation of client's CURRENT/ MOST RECENT mental health diagnosis.** Documentation can include an initial psychiatric assessment, psychiatric progress note, treatment plan, discharge summary, etc. listing client's current / most recent diagnosis given or signed off by a psychiatrist, psychologist, psychiatric nurse practitioner, LCSW-R, LCSW, LMHC-D, LMFT-D. ***Please only include the minimum amount of information necessary.***

  - **Signed consent forms** for all mental health treatment providers (e.g. outpatient mental health provider, any psychiatric hospitals where the client has been treated in the past year, etc) so information can be requested as appropriate to obtain necessary/additional information to determine eligibility for services. *Be sure the correct signature section is completed on the consent. Do NOT sign/witness under the section on the consent that states "Request/Authorization" to withdraw consent". That section is only utilized when a client withdraws Consent. If this section is accidently signed, it invalidates the consent and will delay processing of the application until a valid consent is obtained.*

Please mail or fax the completed application and supporting documentation as noted above to the following:

By Mail: Niagara County Dept. of Mental Health & Substance Abuse Services 475 South Transit St. Suite 500 Lockport, NY 14094

By Fax: (716) 278-8130

Should you have questions, concerns and/or would like more information, please contact us at (716) 439-7410 or at (716) 285-3518. We are happy to assist you.

AOT PROGRAM APPLICATION

ASSISTED OUTPATIENT TREATMENT (AOT) / KENDRAW'S LAW PROGRAM DESCRIPTION

Consistent with Mental Hygiene Law 9.60 (Kendra's Law), under the oversight of the Director of Community Services, Niagara County operates a program that provides Assisted Outpatient Treatment (AOT). Enhanced monitored comprehensive behavioral health services are provided to individuals with a mental illness who, in view of their treatment history and present circumstances are unlikely to survive safely in the community without supervision.

Frequently Asked Questions

How do I refer someone to the AOT Program?
Contact the Niagara County Department of Mental Health AOT Program at (716) 285-3518. A staff member will respond to your concerns and questions while gathering information from you about your referral.

How will I know if someone is eligible for the AOT Program?
Eligibility will be determined based on meeting with the individual and/or collaterals, requesting records to determine if the individuals history supports AOT criteria and possibly a psychiatric evaluation. If an individual does not meet AOT criteria, referral to other appropriate services will be offered.

What happens after the initial phone call?
An Assisted Outpatient Treatment Staff Member will begin an investigation through contacts with the individual, the individual's family members and his/her service providers. The staff will also gather treatment records from previous and current service providers.

How does the AOT Program help an individual comply with outpatient treatment?
The AOT staff will work with each individual to achieve and maintain stability and increase life quality through linkage with the most effective and least restrictive services available. The AOT staff will work with the individual to develop an individualized treatment plan and a written contract. Services may include some or all of the following: mental health treatment, drug and alcohol abuse treatment, day treatment, case management, vocational programming and crisis services.

How long does an individual remain in the AOT program?
An individual will remain in *active status* in the program until they have demonstrated clear stability and compliance with the treatment plan for an extended period of time. After that, the individual may move to an Enhanced Voluntary Service Agreement, and a low level of monitoring. After long term compliance with treatment, the AOT case may be closed.

What happens if the individual does not comply with AOT assistance?
After diligent efforts have been exhausted and an individual remains at risk of self-harm or harm to others, a petition for an AOT court order may be initiated with the State Supreme Court system to ensure safety and treatment compliance. The petition, which is a formal statement of facts demonstrating that the person meets the criteria for AOT, must be accompanied by the affidavit of an examining physician. The affidavit must show that the physician examined the person and, with the individual, developed a treatment plan, prior to the filing of the petition, and that the individual meets the programmatic criteria.

To whom is the court order directed?
The court order is directed to both the individual receiving AOT and the local director of the AOT program. The order will require the individual to accept the treatment deemed necessary by the court, and will require the local director to furnish such treatment through local service providers. This provides greater accountability of service providers in serving the consumer.

How long does the AOT court order remain in effect?
The initial court order is effective for up to 1 year from the date of the order. The order can be extended for successive periods of up to 1 year each, but any application to extend AOT requires a showing that the person continues to meet all of the AOT criteria. If an individual has had a court order expire within the last six months and has experienced a substantial increase in symptoms impacting major life activities, the court order can be reissued following the statute.

ASSISTED OUTPATIENT TREATMENT (AOT) / KENDRA'S LAW PROGRAM
For adults ages 18 and older

Only complete this section if making referral for AOT/Kendra's Law status. (Pages 5 - 9)

CLIENT NAME: **DOB:**

☐ Diagnosed with a mental illness **(specify the following)**
(1. Most recent DSM diagnosis, 2. Date of diagnosis & 3. Name/credentials of person who made diagnosis)
1.
2.
3.

AND

☐ Is unlikely to survive in the community without supervision, based on a clinical determination **(explain):**

AND

☐ Has a history of non-compliance with treatment for mental illness which has led to either:
☐ TWO psychiatric hospitalizations (or forensic incarcerations) within the preceding THREE years (if known, list dates, hospitals & circumstances):

OR

☐ at least ONE act of violence toward self or others, or threats of serious physical harm to self or others, within the preceding FOUR years (if known, list dates & circumstances):

AND

☐ Is unlikely to accept treatment recommended/voluntarily participate in treatment plan (state history/current refusals):

AND

☐ Is in need of AOT to avoid a relapse or deterioration which could lead to serious harm to self or others (specify):

AND

☐ Will likely benefit from AOT (specify anticipated outcome):

AND

☐ AOT is **LEAST RESTRICTIVE** treatment alternative (specify):

AND/OR

☐ Client was on a court order for assisted outpatient treatment which has expired within the last six months, and since the expiration of the order, the person has experienced a substantial increase in symptoms of mental illness and such symptoms substantially interferes with or limits one or more major life activities.

AOT PROGRAM APPLICATION
AOT APPLICATION CONTINUED

☐ **Reason for application / presenting problem:**

☐ **Individual is currently in crisis and may need immediate Mental Health Intervention.** ***Refer this individual to the Niagara County Crisis Hotline immediately (716) 285-3515.***

CLIENT INFORMATION			
For NCDMH use—client ID #			
First Name	**Middle Initial**	**Last Name**	
Social Security #	**Date of Birth**	**Age**	**Gender** ☐ Male ☐ Female ☐ Transgender
Current Street Address	**Town**		**Zip**
Home Phone #	**Cell Phone #**		**Work / Other Phone #**
Health Insurance: ☐ Yes ☐ No ☐ Unknown ☐ **Application Pending for**: ☐ Medicaid ☐ Medicare ☐ Managed Care ☐ Other ***Specify pending date of approval***:			
If Medicaid – provide #	**Medicaid Active**? ☐ Yes ☐ No	**If no, eligible**? ☐ Yes ☐ No ☐ Unknown	
If Medicare – provide #	**Other Insurance Type:** **Policy #**	**Policy Holder:**	
Current benefits ☐ SSI ☐ SSD ☐ Survivor's ☐ Public Assistance ☐ Unemployment ☐ Earned Income ☐ None ☐ Unknown			
Ethnicity (check all that apply) ☐ White/Non-Hispanic ☐ African American ☐ Latino ☐ Hispanic ☐ Native American/Alaskan ☐ Asian ☐ Unknown ☐ Other (*specify):*			
Brief physical description (approximate height, weight, hair / eye color, identifying features – i.e. piercings, tattoos, etc.)			
Special Needs & Preferences (physical, medical, visual, hearing, cultural/religious, language, writing, reading, developmental disability) (*specify):* **Are services required in a language other than English?** ☐ No ☐ Yes *If yes, specify language*:			
Marital Status ☐ **S**ingle never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown ☐ Other *(specify)*			
Living Situation ☐ Unknown ☐ Alone ☐ With Child(ren), # of persons in home: _____ ☐ With other family / friends, # of persons in home: _____ ☐ Homeless/Streets ☐ Emergency Shelter ☐ OMH Facility *(specify type)* ☐ Hospital *(specify type)* ☐ OCFS Facility *(specify type)* ☐ OASAS Facility *(specify type)* ☐ Jail/Correctional Facility *(specify current charges/ convictions and release date)* ☐ Other *(specify)*			

Is the living environment safe? ☐ Yes ☐ No ☐ Unknown

Are there weapons in the home? ☐ Unknown ☐ No ☐ Yes ***If yes, specify type***:

Niagara County Department of Mental Health & Substance Abuse Services
Permission to Use & Disclose Confidential Information

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of § 9.60 of the New York State Mental Hygiene Law, § 33.13 of the New York State Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA) (20 USC 1232g). It is not for use for HIV-AIDS related information. Although it includes many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under the federal HIPAA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment or health care operations. (See 45 CFR 164.506.)

1. I hereby give permission to use and disclose health, mental health, alcohol and drug, and educational records as described below.
2. The person whose information may be used, disclosed or re-disclosed is:

Client Name:	**Date of Birth:**

3. The information that may be used, disclosed or re-disclosed includes health, mental health, alcohol/drug, school /educational records.
4. This information may be disclosed/ re-disclosed **by** *any person or organization that possesses information to be disclosed; the persons or organizations listed in* ***Attachment A****; and the persons or organizations listed in* ***Box 1****.*

Box 1

5. This information may be disclosed or re-disclosed **to** *any person or organization that needs the information to provide service to the person who is the subject of the record, and/or pay for those services, and/or engage in quality assurance and/or other health care operations related to that person, and/or the person or organizations listed in* ***Attachment A****, and/or the persons or organizations listed above in* ***Box 1.***

6. The purpose for which this information may be used, disclosed or re-disclosed include:
   - Evaluation of eligibility to participate in a program supported by the Niagara County Department of Mental Health and Substance Abuse Services;
   - To determine initial and continuing home & community based services (i.e. Mobile Integration Team services, Hospital Diversion, Crisis Service Coordination, Forensic Case Management, Partnership for Healthy Aging, Assertive Community Treatment, Assisted Outpatient Treatment, care management, etc.), and treatment eligibility, level of service / care, and needs;
   - To make recommendations for appropriate services and treatment;
   - To plan and coordinate services and treatment, and for service and treatment delivery;
   - To complete utilization review of assigned service(s) and treatment(s);
   - To access data in PSYCKES to determine service eligibility and level of service need;
   - Health Care Operations such as quality assurance;

   I further understand that:
   - Only this information may be obtained, used, disclosed and re-disclosed as a result of this authorization.
   - This information is confidential and cannot be legally disclosed without my permission.
   - It is the role of the AOT Program to oversee the use of home & community based services (i.e. Mobile Integration Team services, Hospital Diversion, Crisis Service Coordination, Forensic Case Management, Partnership for Healthy Aging, Assertive Community Treatment, Assisted Outpatient Treatment, care management, care coordination, etc.) and residential services in Niagara County and to decide what level of service is most appropriate for each client in light of the demands for those services.
   - I have a right to inspect and copy my own protected health information to be used, disclosed and/or re - disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524).

7. I understand that New York and federal law prohibits persons that receive mental health, alcohol, or drug abuse, and education records from re-disclosing those records without permission. I also understand that not every organization that may receive a record is required to follow the federal HIPAA rules governing use and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NO OTHER PURPOSE.

8. **Periodic Use / Disclosure:** Unless my permission is withdrawn in writing I understand that this consent / authorization **will remain in effect as long as I continue to receive the services covered under this authorization** for the purposes described above as often as necessary to fulfill the purposes identified above.

9. ***If none, skip this part:*** *(ONLY FILL OUT THIS PART IF YOU ARE PLACING LIMITATIONS EXPIRATION OF PERMISSIONS AND/OR LIMITATIONS ON PERMISSIONS),*
   a. *This permission expires (check any that apply)*
      On the following date: _____
      Upon the following event: _____
   b. *This permission is limited as follows:*
      Permission only applies to the records for the following time period:_____to_____
      Other limitation: _____

10. I understand that this permission may be revoked. I have received a Notice of Privacy Practices, and understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given. **I hereby affirm and certify I have read the entire foregoing Consent, I understand all of its terms, I agree to be bound by all of its terms, I agree to comply with all of its terms, and I am signing this Consent upon my free will and volition.**

I am the person, or personal representative of the person, whose records will be used, disclosed and/or re-disclosed. I give permission to use, disclose and/or re-disclose my records as described in this document.

_____ _____

Signature of Client or legal Personal Representative — Date

_____ _____

Personal Representative's Name (as applicable / for clients under the age of 18) — Relationship to Person for whom you are signing

Niagara County Department of Mental Health & Substance Abuse Services
Permission to Use & Disclose Confidential Information

List of agencies with which the Niagara County AOT Program and Committee is permitted to exchange information - Attachment A

This permission to use, disclose and/or re-disclose records applies to the following organizations and people who work at those organizations as appropriate. These organizations work together to deliver services to residents of Niagara County.

• **Beacon Center**	• **Monroe County Sheriff Department**
• **Best Self Behavioral Health** *(including all associated programs)*	• **Monroe Plan**
• **BestSelf Health Home** *(includes all associated care management agencies)*	• **New York State Court System**
• **BryLin Hospitals, Inc.**	• **Niagara County Attorney's Office**
• **Buffalo City Mission**	• **Niagara County Courts**
• **Buffalo General Hospital**	• **Niagara County Department of Mental Health & Substance Abuse Services** *(including all associated programs)*
• **Buffalo Psychiatric Center** *(including all associated programs)*	• **Niagara County Department of Social Services**
• **Buffalo VA (Veterans Administration) Hospital/Programs** *(including all associated programs)*	• **Niagara County Law Enforcement Agencies** (Sheriff, Niagara Falls, New York State Police, Town of Niagara, Lewiston, Lockport, Barker, North Tonawanda, Somerset, Youngstown, Middleport)
• **Catholic Charities of WNY** *(including all associated programs)*	• **Niagara County Office for the Aging**
• **Catholic Health System** *(including all associated programs)*	• **Niagara County Probation Department**
• **Cazenovia Recovery Systems**	• **Niagara Falls City Court**
• **Central NY Psychiatric Centers and satellite offices**	• **Niagara Falls Memorial Medical Center (NFMMC)** *(including all associated programs)*
• **Community Health Center of Buffalo (CHCOB)** • **Community Health Center of Niagara (CHCON)**	• **Niagara Gospel Rescue Mission**
• **Community Services for Every1**	• **Niagara Threat Advisory Group**
• **Community Missions of Niagara Frontier, Inc.** *(including all associated programs)*	• **Northpointe Council, Inc.**
• **Dale Association**	• **North Tonawanda City Court**
• **DeGraff Medical Park**	• **NYS Department of Corrections and Community Supervision (includes Parole)**
• **DePaul Community Services** • **DePaul Properties** • **Living Opportunities of DePaul**	• **Orleans Community Health Medina Memorial Hospital**
• **DePaul Community Services** • **DePaul Properties** • **Living Opportunities of DePaul** • **East Amherst Psychology Group**	• **Orleans County Sheriff Department** • **Pathways, Inc. Community Residence**
• **Encompass Health Home** *(includes all associated care management agencies)*	• **Person Centered Services**
• **Endeavor Human Services** *(including all associated programs)*	• **Pinnacle Community Services (***formerly Family & Children's Services of Niagara)*
• **Empower (formally Niagara Cerebral Palsy)**	• **Prime Care Inc.**
• **Erie County Department of Mental Health** *(including Single Point of Entry / Access– SPOE / SPOA and AOT– Program)*	• **Prime Care Medical, Inc at the Niagara County Jail**
• **Erie County Law Enforcement Agencies (**including but not limited to Sheriff, Buffalo, Amherst, Tonawanda, Cheektowaga**)**	• **Psychotherapy Associates of Niagara**
• **Erie County Medical Center (ECMC)** *(including all associated programs)*	• **Recovery Options Made Easy, Inc.** *(formerly Housing Options Made Easy, Inc.)*
• **Evergreen Health Services** *(including all associated programs)*	• **Rochester Psychiatric Center**
• **Federal Bureau of Investigation**	• **Save the Michaels of the World** *(including all associated programs)*
• **Genesee County Sheriff Department**	• **Specialty / Treatment Courts within Niagara County**
• **Greater Buffalo United Healthcare Network (GBUHN)**	• **Spectrum Health and Human Services** *(including all associated programs)*
• **Health Homes of Upstate NY (HHUNY)** *(includes all associated care management agencies)*	• **Strong Memorial Hospital**
• **Horizon Health Services** *(including all associated programs)*	• **Suburban Psychiatric Associates**
• **Jewish Family Services**	• **Transitional Services Inc.**
• **Kaleida Health** *(including all associated programs/facilities)*	• **Venture Forthe**
• **Kenmore Mercy Hospital**	• **UBMD Physicians Group**
• **Lockport CARES**	•
• **Lockport City Court**	• **WNY Developmental Disabilities Regional Office**
• **Lockport Memorial Hospital**	• **WNYIL - Independent Living Project / Independent Living of Niagara County**
• **Mental Health Association in Niagara County (MHA)**	• **WNY Office of Mental Health Field Office**
• **Mental Health Advocates of WNY**	• **WNY Office of Addiction Services & Supports**
• **Mental Hygiene Legal Services**	• **YWCA of Western NY**

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Please ensure this page is included with the completed application. If there is any entity listed above that the referred individual objects to, please cross out that entity and have the individual initial next to it.

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES
ASSISTED OUTPATIENT TREATMENT (AOT) APPLICATION

FAMILY / COLLATERAL CONTACT CONSENT FORM (2 pages):

AUTHORIZATION FOR RELEASE OF INFORMATION	Patient Name (Last, First, M.I.) Sex Date of Birth
	Facility/Agency Name: **Niagara County Dept of Mental Health & Substance Abuse Services Assisted Outpatient Treatment (AOT) & Agencies Represented on the Committee**

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information (for other than treatment, payment, or health care operations purposes), in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed (PLEASE CHECK AS APPROPRIATE):

☐ Identifying Information ☐ Presence in treatment/services ☐ Information necessary to engage in / coordinate services
☐ Medical Information/Concerns ☐ Lethality/Risk Concerns ☐ Diagnosis/Prognosis/Progress in Treatment/Services
☐ Behavioral/Mental Health Information ☐ Substance use/abuse Information ☐ Legal/Criminal Justice Status
☐ **Other (identify):** _____

Purpose or Need for Information

1. This information is being requested: (PLEASE CHECK ONE)
☐ by the individual or his/her personal representative; or ☐ By Other (please describe) _____
1. The purpose of the disclosure is (PLEASE DESCRIBE): ☐ Continuity of Care ☐ Coordination of Services
☐ Facilitate Referrals/Linkage with Needed Services ☐ **Other (identify):** _____

From/To: Name, Address, & Title of Person/ Organization/Facility/Program Disclosing Information and To which Disclosure is to be Made ***NOTE:*** *If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*	**To/From:** Name, Address, & Title of Person/Organization/ Facility/Program to Which this Disclosure is to be Made and which is Disclosing Information. ***NOTE:*** *If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*
Name: Niagara County Dept. of Mental Health & Substance Abuse Services AOT Program which includes represented agencies / service / treatment / residential – housing providers referred to / involved in care . 475 South Transit Street Suite 500, Lockport, NY 14094; Phone: (716) 285-3518; Fax: (716) 278-8130	**Family / Collateral**

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program (s) identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (**Niagara County Dept. of Mental Health**), shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524.

Facility/Agency Name: **Niagara County Dept of Mental Health & Substance Abuse Services Assisted Outpatient Treatment (AOT) Program & Agencies Represented on the Committee**	Patient's Name (Last, First, MI)	ID #

B. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as often as necessary to fulfill the purpose identified above.
My authorization will expire:

☐ When I am no longer receiving services from **Niagara County Dept. of Mental Health & Substance Abuse Services AOT Program and agency assigned that is providing ACT, care management and/or residential services**

☐ Other (specify) _____

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

☐

Signature of Patient or Personal Representative Date

Patient's Name (Printed)

Personal Representative's Name (Printed)

_____

Description of Personal Representative's Authority to Act for the Patient (*required if Personal Representative signs Authorization*)

D. 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 personal representative.

WITNESSED BY:
Staff person's name and title
Authorization provided to: Date:

To be Completed by Facility:
Signature of Staff Person Using/Disclosing Information :

Title:

Date Released:

PART 2: REVOCATION of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

I hereby refuse to authorize the use/disclosure indicated in Part I, to the Person/Organization/Facility/Program whose name and address is: _____

Signature of Patient or Personal Representative Date

Patient's Name (Printed)

Personal Representative's Name (Printed)

Description of Personal Representative's Authority to Act for the Patient (*required if Personal Representative signs Revocation of Authorization*)

_____