

SINGLE POINT OF ACCOUNTABILITY FOR CHILDREN & YOUTH

CONSENT FOR RELEASE OF INFORMATION	AGENCY NAME					
NAME (Last, First, Middle)		SEX M <input type="checkbox"/> F <input type="checkbox"/>		DOB		
Extent or nature of information to be disclosed <i>(including if there be any, record with respect to alcoholism & substance abuse):</i>						
Diagnosis		Financial Status		Psychiatric Assessment		
Treatment Plan		Inpatient/Outpatient History		Psycho/Social History		
Purpose or need for information: For placement in Case Management &/or Residential Services						
FROM			→	TO		
Name & Address of Person or Organization disclosing info:			Name & Address of Person or Organization to which disclosure is to be made/ Single Point of Accountability Committee includes representatives from: Binghamton Psychiatric Center, BOCES, Broome County DSS, Broome County Mental Health, Broome County Probation, Catholic Charities, Children's Home of Wyoming Conference, Family & Children's Society, Harbour Program, Lourdes Hospital, Mental Health Association, OMRDD, Private Practitioner, UHS			
FROM			→	TO		
Name & Address of Person or Organization disclosing info: Single Point of Accountability Committee includes representatives from: Binghamton Psychiatric Center, BOCES, Broome County DSS, Broome County Mental Health, Broome County Probation, Catholic Charities, Children's Home of Wyoming Conference, Family & Children's Society, Harbour Program, Lourdes Hospital, Mental Health Association, OMRDD, Private Practitioner, UHS			Name & Address of Person or Organization disclosing info:			
<p>A: I Hereby Authorize the One-time Release of the Above Information to the Person/Organization/Facility/Program identified above. I understand that the Information to be Released is Confidential and Protected from Disclosure. I also Understand that I have the Right to Cancel My Permission to Release Information at any Time.</p> <p style="text-align: center;">My Consent to Release Information Will Expire When Acted Upon, or 90 days From this Date, Whichever Occurs First.</p>						
Signature of Parent/Guardian		Relationship	Date Signed	Signature of Witness	Title	Date Signed
<p>B. I Hereby Authorize the Periodic Release of the Above Information to the Person/Organization/Facility/Program identified Above as Often as Necessary to Plan For/Provide Care and treatment. I understand that the Information to be Released is Confidential and Protected from Disclosure. I also Understand that I have the Right to Cancel My Permission to Release Information at any Time.</p> <p style="text-align: center;">My Consent to Release Information to the Person/Organization/Facility/Program Identified Above Will Expire When I am no longer Receiving Services from such Person/Organization/Facility/Program, or One Year from this Date, Whichever Occurs First.</p>						
Signature of Parent/Guardian		Relationship	Date Signed	Signature of Witness	Title	Date Signed
Record of Information Released						
Signature of Staff Person Releasing Information			Title		Date Released	

H:release of infor single point of entry