This authorization must be completed by the child’s Medical Consenter to use/disclose protected health information in accordance with state and federal laws and regulations.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Child:  |  | DOB: |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Release Records  |  | FROM and/or  |  | TO |  | Release Records |  | FROM and/or |  | TO |
|  |
| The William George Agency  |  | Name/Organization: |  |
| 380 Freeville Road | Street Address: |  |
| Freeville, NY 13068 | City/State/Zip: |  |
| Phone: 607.844.6460  | Phone: |  | Fax: |  |

**Extent or nature of information to be disclosed/obtained** (check all that apply)**:**

|  |  |
| --- | --- |
|  | Educational, medical, psychosocial, psychiatric, and psychological evaluations, treatment plans, summary of progress, and/or discharge summaries |
|  | Entire Medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consultations, billing records, insurance records, medication and dosages, and records sent to you by other health care providers. |
|  | I authorize my information to be verbally discussed.  |
|  | Other:  |  |

**Purpose or Need for Information:** (check all that apply):

|  |  |
| --- | --- |
|  | Service delivery and planning |
|  | Other:  |  |

**Additional Authorization to Release Sensitive Information,** records containing sensitive information **will be only released** if the appropriate items are initialed by the patient/authorized representative below(initial all that apply):

|  |  |
| --- | --- |
|  | Alcohol/Drug Treatment |
|  | Mental Health Information (except psychotherapy notes) |
|  | HIV/AIDS/Reproductive Health Related Information |

My signature below indicates that I understand the following:

1. I may revoke this authorization in writing at any time, except to the extent The William George Agency for Children’ Services has taken action in reliance to this authorization.
2. This authorization is voluntary. My treatment, payment or eligibility for benefits will not be conditions upon my authorization of this disclosure.
3. I have a right to a signed copy of this authorization.
4. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.
5. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
6. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493. This agency is responsible for protecting my rights.
7. This authorization will automatically expire **within one year** of being discharged from The William George Agency for Children’s Services unless previously revoked by the child’s legal guardian.

I have read and fully understand this authorization form. By signing below, I authorize **The William George Agency for Children’s Services located at 380 Freeville Road, Freeville, NY 13068** to obtain, use and/or disclose my protected health information consistent with the terms of this authorization, which will be effective on the date that it is signed.

**Patient/Legal Guardian/Authorized Representative**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | Signature: |  | Date: |  |
| Relationship (if not patient): |  |

**Witness**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | Signature: |  | Date: |  |