

MENTAL HEALTH SERVICES SINGLE POINT OF ENTRY

290 Front Street • Binghamton, New York 13905 (607) 723-9991 • Fax (607) 773-7891

of the Roman Catholic Diocese of Syracuse

Broome County

Dear Referral:

Enclosed please find a Catholic Charities Central Referral Form packet for Mental Health Services and Residential Programs. Three requirements for mental health services with Catholic Charities are:

- 1. A mental health diagnosis and
- 2. A signed and witnessed release of information
- 3. 18 years of age or older

Please take this Referral Form to your therapist and have him/her fill it out indicating which services are recommended for you. Instructions for filling out this form are on the first page of the packet. When completed, please send to:

Central Referral Office Catholic Charities Mental Health 290 Front Street Binghamton, NY 13905

If you or your therapist should have any questions regarding this form, please do not hesitate to contact the Single Entry Coordinator at 723-9991, extension 317.





CATHOLIC CHARITIES ADULT MENTAL HEALTH AND RESIDENTIAL PROGRAMS CENTRAL REFERRAL FORM

SEND TO: Catholic Charities
Central Referral Office

290 Front Street

Binghamton, New York 13905

Phone: (607) 723-9991 Fax: (607) 773-7891

Catholic Charities offers a wide range of Mental Health Services and Residential Services for adults with a mental health diagnosis requiring assistance to live successfully in the community. Use this referral form to refer an individual to one or more services.

This referral form and the consent for release of information will begin the initial screening process for all services requested on the form. Once received, referrals will be routed to all services checked.

- Acceptance into any Catholic Charities Adult Mental Health and Residential Programs will not be contingent upon participation in other Catholic Charities Services.
- Requesting a program does not assure acceptance in that program.

Incomplete referrals may not be routed until all information is received and may be returned to the referral source for completion for such items as an incorrect or missing release of information or if a program request is absent.

- Please include as much detail as possible to assist with best serving the consumer.
- Certain services will require additional information and assessments. You will be notified if that is necessary.
- Final disposition letters will be sent to each referral source and/or consumer.
- Specific questions regarding requested programs may be directed to the identified program at 723-9991, Residential Services at 723-1804 or Four Seasons Club at 773-1184.

Agency Name:	Referral date
Referring Person (Print):	Title
Address:	
Phone #:(Ext	
For Case Management and Residential referrals, Agency Referral Sources are welcome case is presented. Do you wish to attend? Yes No Comments:	
AOT Candidate: Yes No Current AOT Client: Yes To be completed by State Psychiatric Center only: SPC Long Stay Yes	
1. Consumer Information	
Consumer Name: Last First	MI ;
Current Address:	Apt. #
City: State:	Zip:
Phone #: _()	Female DOB:
Social Security #: Highest Level of Educa	ation Completed
Marital Status: Single Married Divorced Separated Widow	ed Veteran: 🗌 No 🔲 Yes
CSS Certified: No Yes Date	Number
Emergency Contact Person:	Telephone #: _()
Relationship to Person:	
Number of children living in the home under the age of 18:	

CONSUMER NAME

2. Please check the Box(es) for Program(s) Requested.

Referral will not be processed unless a program is requested and all paperwork is included:

1	Programs	Referral Packet	Releases of Information		Psychiatric	Form	Community Support Services	CSS Transportation
		Programs	Pages Single Entry Pages Case Managem	Case Management/ Residential	Catholic Charities	Assessment/ Evaluation	OMH 143a	Functional Assessment Worksheet
	Single Entry (SE) Case Management Services	х	х		х			
	SE Residential Services Community Residence	х	х		х			
	SE Residential Services Certified Apartment Program	х	х		х			
	Supported Housing (IAP)	х	х		X			
	Four Seasons	х		Х	х	х	х	
	CSS Transportation Program	х		х		х	х	x
	Portfolios Café Community Employment	x		х	x			
	Job Club	х		Х	х			

	Job Club X	X X
3.	DSM-IV Diagnosis: (Code and Description required. Code	Include current psychiatric and chemical addiction diagnoses.) Description
	Axis III	
4.	Financial Status: (Monthly) SSI \$	SSD \$ TANF \$ VA \$
	Medicare #:	Medicaid #:
	Private Ins.:	Attach copies (Medicaid, Medicare, and third party insurance cards)
	Managed Care Insurance Provider: Excellus F	idelis
	Rep-Payee Services Needed: Yes No Ur	
	Current Rep-Payee: No Unknown Ye	es Name

CONSUMER NAME	
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5. Health Care Providers:					
A. Primary Care Physician Name:					
Address:					
B. Outpatient Psychiatrist's Name:					
Address:					
C. Current Therapist Name:					
Address:Telephone #:()					
D. Current Case Management Services: Yes No					
(If yes, list agency):					
6. Psychiatric Treatment (Include Forensic): A. Inpatient History: (include dates and facility names)					
A. Inputerix Filotory. (Include dates and lability frames)					
B. Outpatient History: (include dates and facility names)					
7. Chemical Dependence History of Substance/Alcohol Abuse: Yes No Unknown					
A. Inpatient History: (include dates and facility names)					
B. Outpatient History: (include dates and facility names)					
Pattern/Frequency of Current Use (include drugs of choice):					
Current Treatment:					
8. Co-occurring Disabilities/Conditions: (Check all that apply)					
None ☐ Blindness ☐ Impaired ability to walk ☐ Drug or alcohol abuse ☐ Visual impairment ☐ Wheelchair required					
☐ Tobacco ☐ Deaf ☐ Amputee					
☐ Mental retardation or developmental disorder ☐ Hearing impairment ☐ Bedridden ☐ Speech impairment ☐ Incontinence					
Cognitive disorder Unable to read/write Gambling					
Seizure disorder Diabetes Other; specify					
Medical conditions that require special services? ☐ Yes ☐ No					
If yes, explain:					

9. High Risk Alerts: (Check if histo	ry of the following)	
Suicide /Attempts	☐ Assault	☐ Frequent Crisis Requiring Readmission
Suicidal Threats	Medical Issues	Non-compliance with Medication
Fire Setting	Inappropriate Sexual Behavior	Non-compliance with Appointments
☐ Violent☐ Other (Specify)	Self-Injurious Behaviors	☐ Victim of Physical/Sexual Abuse
If checked, provide dates and a brief	explanation:	A STATE OF THE STA
in oncokou, provide dates and a sile.	on prantation in	
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No constitution de la constitución de la constituci		
10. Criminal Justice System. (Chec	k if current or past history of the followin	g - Provide name of Probation/Parole Officer if current.)
☐ Conviction of a Crime ☐ Prob	ation, expires	☐ CPL Status, expires
☐ Charges Pending ☐ Paro	le, expires	☐ Order of Condition, expires
☐ Currently Incarcerated		☐ Order of Protection, expires
Provide details; please include dates	f known:	
Accelerate said of the Commence of the Commenc		U SUBSTITUTE OF THE STATE OF TH
ALCOHOL STATE OF THE STATE OF T		
11. Community Living Needs	THE PROPERTY OF THE PROPERTY O	
Advocacy	Education	al Referrals Symptom Management
Budgetary Support		s to Self-Help Transportation
Connection to Psychiatrist	Family Support	ication Compliance
Coordination of Services		patient Treatment
Crisis Intervention		chosocial Rehab
Daily Living Skills DSS (Medicaid, Food Stamps)		stance Abuse Services
If checked, provide brief narrative:		
it checked, provide blief harrative.		
Machine Williams Committee		
	and the second s	· · · · · · · · · · · · · · · · · · ·
12. History Of Homelessness:	Yes No Currently Ho	omeless
How long at current address		
Number of residences in past 2 years		
Brief explanation:		

	CONCUMED NAME
40	CONSUMER NAME
13.	Cultural Issues (for example, Language, social interaction, dietary restrictions):
_	
14.	Ethnicity: White African-American/Black Asian/Asian American Native American Latino/Hispanic Pacific Islander
45	
15	Treatment Team Recommendation:
, 	
_	
16.	Reason for Referral:
_	A
17.	Consumer's Statement (optional):
_	
	OFFICE OF THE PROPERTY OF THE
This	statement completed by: Consumer Family Member Advocate Other

Signature

Signature

I participated in completing this form.

Consumer (Print)

Witness (Print)

Consumer did not participate.
Referral completed without consumer present.

Date

Date

				CONSUMER N	AME		
18.	. Current Medications:		□No	Unknown	Copy Attached		
	Medication		Dosage	Frequency	у	Prescribing Physician	
			-	·		······································	
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				30-511-01-01-0			

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FOR OFFICE USE ONLY Copies Routed to: CC Privacy Practices Form Received							
	Case Management	☐ Transpo	ortation	Residential	□ Sı	upported Housing	
	Four Seasons	☐ Portfolio	os	☐ Job Club			

☐ Four	Seasons	Portfolios	☐ Job Club	
DISPOSI	TION (for Single E	Entry use only)		THE RESIDENCE OF THE PROPERTY
Date(s) i	Reviewed:			
Status:	☐ Assigned to T	ransitional Case Manag	ement:	
	☐ Program assi	gned:		
	☐ Approved for	services/housing, put o	n wait list:	
	☐ Not eligible fo	r services; Reason:		
	☐ Other:			
		ontacted:		

(MHS Rev 2/12)

Sponsored By: Catholic Charities of Broome County

290 Front Street, Binghamton, New York 13905

	Signature of Witness	Name/Title	Date
	I HAVE WITNESSED THE EXEC	CUTION OF THIS AUTHORIZATION.	
	Printed Name of Personal Representative	Description of Authority of Personal Representative	
	Signature of Consumer or Personal Representative	Printed Name of Consumer	Date
t. The fac	at I authorize the use of my health information as set forth in this docu cility, its employees, officers and physicians are hereby released from cated and authorized herein.	iment. By signing this authorization, I acknowledge that any legal responsibility or liability from the disclosure of	at I have read and understand of the above information to the
	ther		
	ne Year from this Date;	When acted upon; Other	
above a	ed above to the Person/Organization/Facility/Program identified soften as necessary to fulfill the purpose identified above, and this ation will expire: //hen I am no longer Receiving Services from Single Point of Entry	above to the Person/Organization/Facility/Program in authorization will expire:	dentified above and this
	authorize the periodic use or disclosure of the information	I hereby authorize the one-time use or disclosure of	
	y permit the use/disclosure of the indicated PHI to the Person/Or Only this information may be used/disclosed as a result of this at This information is confidential and cannot legally be disclosed of If this information is disclosed to someone who is not required to conclone the protected; I have the right to take back this authorization at any time. This remy revocation does not affect information already disclosed becausing this authorization is voluntary and my refusal to sign will I have the right to inspect and copy my own PHI to be used/disclosed.	uthorization; or redisclosed without my permission; omply with federal privacy protection regulations, then it revocation must be in writing on a form provided by Catholause of my earlier authorization; not affect treatment, payment, enrollment or eligibility of	may be redisclosed and would lic Charities. I am aware that
Note:	if the same information is to be disclosed to multiple parties for t	the same purpose, for the same period of time, this	authorization will apply
ığ ı	se or need for information: By the individual or his/her personal representative to facilitate p Other (describe)	lacement in Case Management and/or Residential S	Services; or
Descri	Treatment PlanPsyc	dates where appropriate. tient/Outpatient History chiatric Assessment chosocial History & Assessment	
Bingh Cente United Broon Peopl Coord Broon	amton Health Center & Community Treatment & Recovery r, Broome County Dept. of Social Services, Project Uplift, if Health Services & New Horizons, Addictions Center of the County, Fairview Recovery Services Inc., NYS Office for the With Developmental Disabilities, Broome County Reentry inator, Monroe Plan for Medical Care, Catholic Charities of the County	Catholic Charities Single Point of Entry 290 Front Street Binghamton NY 13905	
	I authorize an exchange of PHI between: LE ENTRY COMMITTEE (Including Representatives from): ne County Mental Health Dept. Services, Greater	<u>AND</u> : (Name, address, title of person/organization	on/facility/program):
Regul author	ations that governs the release of drug & alcohol records. A separate ization is required to use or disclose confidential HIV information.	SEX: MF	
accord of co	dance with State & Federal laws & regulation that govern the release infidential records, as well as Title 42 of the Code of Federal	CONSUMER'S DATE OF BIRTH:	*
repres	uthorization must be completed by the consumer or his/her personal centative to use/disclose Protected Health Information (PHI) in	CONSUMER NAME:	

Sponsored By: Catholic Charities of Broome County

290 Front Street, Binghamton, New York 13905

	Signature of Witness	Name/Title	Date
	I HAVE WITNESSED THE EXEC	CUTION OF THIS AUTHORIZATION.	
	Printed Name of Personal Representative	Description of Authority of Personal Representative	
	Signature of Consumer or Personal Representative	Printed Name of Consumer	Date
t.	certify that I authorize the use of my health information as set forth in this docu The facility, its employees, officers and physicians are hereby released from xtent indicated and authorized herein.	iment. By signing this authorization, I acknowledge that I any legal responsibility or liability from the disclosure of the	have read and understan ne above information to th
_	□ Other		
	☐ One Year from this Date;	☐ When acted upon; ☐ Other	
	above as often as necessary to fulfill the purpose identified above, and this authorization will expire: When I am no longer Receiving Services from Single Point of Entry	authorization will expire:	tined above and tine
	I hereby authorize the periodic use or disclosure of the information described above to the Person/Organization/Facility/Program identified	I hereby authorize the one-time use or disclosure of the above to the Person/Organization/Facility/Program iden	
	 If this information is disclosed to someone who is not required to cono longer be protected; I have the right to take back this authorization at any time. This remy revocation does not affect information already disclosed becausing this authorization is voluntary and my refusal to sign will. I have the right to inspect and copy my own PHI to be used/discked. 	omply with federal privacy protection regulations, then it may vocation must be in writing on a form provided by Catholic Gause of my earlier authorization; not affect treatment, payment, enrollment or eligibility of be	Charities. I am aware that
	 I hereby permit the use/disclosure of the indicated PHI to the Person/Or Only this information may be used/disclosed as a result of this at This information is confidential and cannot legally be disclosed or 	uthorization;	stang that:
ŀ	to all parties listed here.		
	Purpose or need for information: By the individual or his/her personal representative to facilitate p Other (describe) Note: if the same information is to be disclosed to multiple parties for the same information is to be disclosed to multiple parties.	· · · · · · · · · · · · · · · · · · ·	
		hosocial History & Assessment	
		tient/Outpatient History hiatric Assessment	
	Broome County Description of Information to be used/disclosed is as follows: Include	dates where appropriate.	
	United Health Services & New Horizons, Addictions Center of Broome County, Fairview Recovery Services Inc., NYS Office for People With Developmental Disabilities, Broome County Reentry Coordinator, Monroe Plan for Medical Care, Catholic Charities of Broome County	·	
	Binghamton Health Center & Community Treatment & Recovery Center, Broome County Dept. of Social Services, Project Uplift,		
	SINGLE ENTRY COMMITTEE (Including Representatives from): Broome County Mental Health Dept. Services, Greater		71 0 7
	l authorize an exchange of PHI between:	SEX: MFF	facility/program):
	Regulations that governs the release of drug & alcohol records. A separate authorization is required to use or disclose confidential HIV information.	CONSUMER'S DATE OF BIRTH:	
į	accordance with State & Federal laws & regulation that govern the release of confidential records, as well as Title 42 of the Code of Federal		
	This authorization must be completed by the consumer or his/her personal representative to use/disclose Protected Health Information (PHI) in	CONSUMER NAME:	

Sponsored By: Catholic Charities of Broome County

290 Front Street, Binghamton, New York 13905

	□ Other	ument. By signing this authorization, I acknowledge that I have read and understand
	One Year from this Date;	Other
	described above to the Person/Organization/Facility/Program identified above as often as necessary to fulfill the purpose identified above, and this authorization will expire: When I am no longer Receiving Services from Single Point of Entry	above to the Person/Organization/Facility/Program identified above and this authorization will expire: When acted upon;
	I hereby authorize the periodic use or disclosure of the information	I hereby authorize the one-time use or disclosure of the information described
		evocation must be in writing on a form provided by Catholic Charities. I am aware that ause of my earlier authorization; not affect treatment, payment, enrollment or eligibility of benefits; osed as provided in 45CFR 164.524.
	no longer be protected;	comply with federal privacy protection regulations, then it may be redisclosed and would
l	This information is confidential and cannot legally be disclosed of this area.	
l	 I hereby permit the use/disclosure of the indicated PHI to the Person/On Only this information may be used/disclosed as a result of this at 	
ŀ	to all parties listed here.	the same purpose, for the same period of time, this authorization will apply
-	Purpose or need for information: By the individual or his/her personal representative to facilitate p Other (describe)	
-		chosocial History & Assessment
	Treatment PlanPsyc	tient/Outpatient History chiatric Assessment
	Description of Information to be used/disclosed is as follows: Include	
	Coordinator, Monroe Plan for Medical Care, Catholic Charities of Broome County	
	Broome County, Fairview Recovery Services Inc., NYS Office for People With Developmental Disabilities, Broome County Reentry	±
	United Health Services & New Horizons, Addictions Center of	
	Binghamton Health Center & Community Treatment & Recovery Center, Broome County Dept. of Social Services, Project Uplift,	
1	Broome County Mental Health Dept. Services, Greater	
	I authorize an exchange of PHI between: SINGLE ENTRY COMMITTEE (Including Representatives from):	AND: (Name, address, title of person/organization/facility/program):
	authorization is required to use or disclose confidential HIV information.	SEX: MF_
	Regulations that governs the release of drug & alcohol records. A separate	CONSUMER'S DATE OF BIRTH:
	accordance with State & Federal laws & regulation that govern the release of confidential records, as well as Title 42 of the Code of Federal	CONOLINEDIO DATE OF DIDTU
	representative to use/disclose Protected Health Information (PHI) in	CONSUMER NAME:
ш	This authorization must be completed by the consumer or his/her personal	

Sponsored By: Catholic Charities of Broome County 290 Front Street, Binghamton, New York 13905

CONSUMER NAME:	
CONSUMER'S DATE OF BIRTH:	
	16 - 1916 - 1 A
AND: (Name, address, title of person/organization	/facility/program):
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,	
dates where appropriate.	
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chiatric Assessment	
chosocial History & Assessment	
lacement in Case Management and/or Residential Se	vices; or
the same purpose, for the same period of time, this a	uthorization will apply
rganization/Facility/Program identified above. Lunde	rstand that:
or redisclosed without my permission;	
comply with federal privacy protection regulations, then it ma	y be redisclosed and would
evocation must be in writing on a form provided by Catholic	Charities. Lam aware that
	enefits;
osed as provided in 45CFR 164.524.	
I hereby authorize the one-time use or disclosure of the	e information described
, , ,	ntified above and this
authorization will expire:	
166"	
☐ Other	
ument. By signing this authorization, I acknowledge that i	have read and understan
rany legal responsibility of hability from the disclosure of	tie above illioithalion to ti
Printed Name of Consumer	Date
i finded realite of Consumer	Dato
Description of Authority of Personal Representative	
CUTION OF THIS AUTHORIZATION.	
Name/Title	Date

Sponsored By: Catholic Charities of Broome County 290 Front Street, Binghamton, New York 13905

	Signature of Witness	Name/Title
	I HAVE WITNESSED THE EXEC	CUTION OF THIS AUTHORIZATION.
	Printed Name of Personal Representative	Description of Authority of Personal Representative
	Signature of Consumer or Personal Representative	Printed Name of Consumer Date
t.	The facility, its employees, officers and physicians are hereby released from the facility, its employees, officers and physicians are hereby released from the indicated and authorized herein.	ament. By signing this authorization, I acknowledge that I have read and understan any legal responsibility or liability from the disclosure of the above information to the
Ц	Other	
Ľ	One Year from this Date;	□ Other
ı.	When I am no longer Receiving Services from Single Point of Entry	☐ When acted upon;
	I hereby authorize the periodic use or disclosure of the information described above to the Person/Organization/Facility/Program identified above as often as necessary to fulfill the purpose identified above, and this authorization will expire:	I hereby authorize the one-time use or disclosure of the information described above to the Person/Organization/Facility/Program identified above and this authorization will expire:
	Signing this authorization is voluntary and my refusal to sign will I have the right to inspect and copy my own PHI to be used/disclosed.	not affect treatment, payment, enrollment or eligibility of benefits;
		vocation must be in writing on a form provided by Catholic Charities. I am aware that ause of my earlier authorization;
l	no longer be protected;	omply with federal privacy protection regulations, then it may be redisclosed and would
l	This information is confidential and cannot legally be disclosed o	
l	 Only this information may be used/disclosed as a result of this au 	uthorization;
ľ	I hereby permit the use/disclosure of the indicated PHI to the Person/Or	rganization/Facility/Program identified above. I understand that:
I	Note: if the same information is to be disclosed to multiple parties for t to all parties listed here.	the same purpose, for the same period of time, this authorization will apply
-	By the Individual or his/her personal representative to facilitate p Other (describe)	<u> </u>
İ	Purpose or need for information:	
	1	chosocial History & Assessment
		tient/Outpatient History chiatric Assessment
	Description of information to be used/disclosed is as follows: Include	
	Broome County	
	People With Developmental Disabilities, Broome County Reentry Coordinator, Monroe Plan for Medical Care, Catholic Charities of	
	Broome County, Fairview Recovery Services Inc., NYS Office for	*
	United Health Services & New Horizons, Addictions Center of	
	Center, Broome County Dept. of Social Services, Project Uplift,	
	Binghamton Health Center & Community Treatment & Recovery	134
	SINGLE ENTRY COMMITTEE (Including Representatives from): Broome County Mental Health Dept. Services, Greater	
	I authorize an exchange of PHI between:	AND: (Name, address, title of person/organization/facility/program):
	authorization is required to use or disclose confidential HIV information.	SEX: MF
	of confidential records, as well as Title 42 of the Code of Federal Regulations that governs the release of drug & alcohol records. A separate	CONSUMER'S DATE OF BIRTH:
	accordance with State & Federal laws & regulation that govern the release	
	representative to use/disclose Protected Health Information (PHI) in	CONSUMER NAME:
	This authorization must be completed by the consumer or his/her personal	

Sponsored By: Catholic Charities of Broome County 290 Front Street, Binghamton, New York 13905

	Signature of Witness	Name/Title	
	I HAVE WITNESSED THE EXEC	CUTION OF THIS AUTHORIZATION.	
	Printed Name of Personal Representative	Description of Authority of Personal Representative	
t. T	tify that I authorize the use of my health information as set forth in this docu he facility, its employees, officers and physicians are hereby released from nt indicated and authorized herein. Signature of Consumer or Personal Representative	ment. By signing this authorization, I acknowledge that any legal responsibility or liability from the disclosure of Printed Name of Consumer	t I have read and understand If the above information to the
	Other	Other	t I have reed and understoo
		☐ When acted upon;	
de ab au	nereby authorize the periodic use or disclosure of the information escribed above to the Person/Organization/Facility/Program identified bove as often as necessary to fulfill the purpose identified above, and this athorization will expire:	I hereby authorize the one-time use or disclosure of above to the Person/Organization/Facility/Program is authorization will expire:	
11	 Only this information may be used/disclosed as a result of this at This information is confidential and cannot legally be disclosed of this information is disclosed to someone who is not required to concloner be protected; I have the right to take back this authorization at any time. This remains revocation does not affect information already disclosed becausing this authorization is voluntary and my refusal to sign will be a lave the right to inspect and copy my own PHI to be used/disclosed. 	uthorization; r redisclosed without my permission; comply with federal privacy protection regulations, then it r vocation must be in writing on a form provided by Cathol use of my earlier authorization; not affect treatment, payment, enrollment or eligibility o	nay be redisclosed and would lic Charities. I am aware that
N to	lote: if the same information is to be disclosed to multiple parties for to all parties listed here.	he same purpose, for the same period of time, this	authorization will apply
P É	, and the second	lacement in Case Management and/or Residential S	Services; or
	DiagnosisInpatTrealment PlanPsyc	tient/Outpatient History hiatric Assessment hosocial History & Assessment	Dr.
F	People With Developmental Disabilities, Broome County Reentry Coordinator, Monroe Plan for Medical Care, Catholic Charities of Broome County Description of Information to be used/disclosed is as follows: Include	dates where appropriate.	
E	Broome County Mental Health Dept. Services, Greater Binghamton Health Center & Community Treatment & Recovery Center, Broome County Dept. of Social Services, Project Uplift, United Health Services & New Horizons, Addictions Center of Broome County, Fairview Recovery Services Inc., NYS Office for		
5	I authorize an exchange of PHI between: SINGLE ENTRY COMMITTEE (Including Representatives from):	AND: (Name, address, title of person/organization)	on/facility/program):
1	Regulations that governs the release of drug & alcohol records. A separate authorization is required to use or disclose confidential HIV information.	SEX: MF	
	accordance with State & Federal laws & regulation that govern the release of confidential records, as well as Title 42 of the Code of Federal	CONSUMER'S DATE OF BIRTH:	
14	This authorization must be completed by the consumer or his/her personal representative to use/disclose Protected Health Information (PHI) in	CONSUMER NAME:	

CONSENT FOR RELEASE OF INFORMATION FOR CATHOLIC CHARITIES MENTAL HEALTH SERVICES 290 Front Street, Binghamton, New York 13905

The same of the sa		
This authorization must be completed by the consumer or his/her personal representative to use/disclose Protected Health Information (PHI) in accordance with State & Federal laws & regulation that govern the release of confidential records, as well as Title 42 of the Code of Federal Regulations that governs the release of drug & alcohol records. A separate authorization is required to use or disclose confidential HIV information.	CONSUMER NAME: CONSUMER'S DATE OF BIRTH: SEX: M F	
I authorize an exchange of PHI between:	AND: (Name, address, title of person/organization	on/facility/program):
Catholic Charitles Mental Health Services 290 Front Street Binghamton, New York 13905	w	
Description of information to be used/disclosed is as follows: Include	dates where appropriate.	
Medication/Past & PresentPsychological and Neurological TestsPsychosocial History & AssessmentDischarge Summary/Treatment PlansOther (Progress Notes)	Medical, Lab & Physical Exam InformFunctional Assessment & EmploymeReferral PacketPsychiatric AssessmentPhysicians Authorization For Restora	nt History
Purpose or need for information: By the individual or his/her personal representative to facilitate a Other (describe)	dmission and appropriate psychiatric rehabilitation	n treatment planning; or
Note: if the same information is to be disclosed to multiple parties for to all parties listed here.	the same purpose, for the same period of time, this	authorization will apply
Only this information may be used/disclosed as a result of this at This information is confidential and cannot legally be disclosed of this information is disclosed to someone who is not required to constone the right to take back this authorization at any time. This remy revocation does not affect information already disclosed becausing this authorization is voluntary and my refusal to sign will have the right to inspect and copy my own PHI to be used/disclosed.	uthorization; or redisclosed without my permission; omply with federal privacy protection regulations, then it vocation must be in writing on a form provided by Catho ause of my earlier authorization; not affect treatment, payment, enrollment or eligibility of	may be redisclosed and would blic Charities. I am aware that
I hereby authorize the periodic use or disclosure of the information described above to the Person/Organization/Facility/Program identified above as often as necessary to fulfill the purpose identified above, and this authorization will expire:	I hereby authorize the one-time use or disclosure of above to the Person/Organization/Facility/Program is authorization will expire:	
☐ When I am no longer Receiving Services from Catholic Charities	☐ When acted upon;	
One Year from this Date;	☐ Other	
Other		
certify that I authorize the use of my health information as set forth in this docut. The facility, its employees, officers and physicians are hereby released from extent indicated and authorized herein.		
Signature of Consumer or Personal Representative	Printed Name of Consumer	Date
Printed Name of Personal Representative I HAVE WITNESSED THE EXEC	Description of Authority of Personal Representative CUTION OF THIS AUTHORIZATION.	
Signature of Witness	Name/Title	Date