



INFORMED CONSENT FOR THE OFFICE OF MENTAL HEALTH RESIDENTIAL TREATMENT FACILITY AUTHORIZATION REVIEW PROCESS

Form fields for Youth Applicant's Name (Last, First, M.I.) and Youth's Date of Birth.

Form field for Youth's Permanent Address.

Form field for Referring Source Name.

Form field for Referring Source Address.

I, or my authorized representative, request that health information regarding the above-named youth's care and treatment be released as set forth on this form. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- List of 7 bullet points detailing the terms of the authorization, including the right to cancel, the review process, and the expiration of consent.

This authorization must be completed by the parent/legal guardian to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.



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NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and HIPAA). The federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and/or HIPAA. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature of Parent

Relationship

Print Name Signed

Date Signed

Signature of Legal Guardian *

Title

Print Name Signed

Date Signed

*Legal documentation indicating authority to sign in lieu of parent(s) listed on birth certificate must be submitted with this form.

Signature of Witness

Title

Print Name Signed

Date Signed

FOR OMH USE ONLY

CONSENT HAS BEEN:

- Revoked in entirety
Partially revoked as follows:
Letter (Attach Copy)

DATE REQUEST RECEIVED:

OMH REPRESENTATIVE RECEIVING REQUEST:

(OMH REPRESENTATIVE'S FULL NAME AND TITLE)



REQUEST FOR DISABILITY DETERMINATION

Name of Youth Applicant: _____

Youth's Date of Birth: _____

This is to request that the Office of Mental Health (OMH) determine whether the above-named youth applicant is disabled for the purposes of the Medical Assistance Program, as designated by the Department of Social Services.

I authorize OMH to review and evaluate any mental health, health, or educational information it has received to assess whether the above-named youth is disabled. I also authorize OMH to request clarification or obtain additional documentation necessary to confirm or verify this information to determine whether he/she is disabled.

I understand that this form is not an application or reapplication for Medical Assistance benefits, and that OMH will be determining whether the above-named youth is disabled but not whether he/she is eligible for Medical Assistance.

Signature of Parent/Legal Guardian

Relationship to Applicant

Date Signed