COUNTY OF OSWEGO
DEPARTMENT OF SOCIAL SERVICES/ DIVISION OF MENTAL HYGIENE

(315) 963-5361
FAX (315) 963-5530

FRANCES V. LANIGAN
Commissioner

OSWEGO COUNTY BUILDING
100 SPRING STREET, PO BOX 1320
MEXICO, NEW YORK 13114

Nicole Kolmsee - Director of Community Services
NKolmsee@oswegocounty.com

Children's Mental Health - Single Point of Access (SPOA)
CONSENT FOR RELEASE OF INFORMATION

I consent to use and disclosure of protected health information for the purpose of arranging services, treatment, payment, and health care operations as described below. This means that information about my child's health will be used by the staff of Oswego County Mental Hygiene Division or disclosed to other people or organizations whenever needed to:

- Provide services to my child or arrange for services by another health care or mental health service provider.
- Arrange for payment for services for my child.
- Operate the business of Oswego County Children's Mental Health Single Point of Access
- Enable Oswego County Mental Hygiene Division to review the quality and appropriateness of care my child receives from mental health organizations that provide services for my child.

I understand that information I choose to disclose pursuant to this consent may be re-disclosed by the recipient of the information. Verbal disclosure may occur among Service Providers during SPOA Committee meetings to determine the most appropriate level of care. Written material will be shared only with those providers whom my child/family is referred to. Most health care providers and all health benefit plans are obligated to follow federal rules and state laws for protection of the privacy of your health information. But those rules and laws do not apply to all organizations. Information may be disclosed to the Government offices of the NYS Office of Mental Health, and NYS Commission on Quality of Care as necessary.

I understand that there is no time limit on this consent.

I also understand that I may revoke this consent at any time.

____
Child's Name

I am the parent/guardian of the person whose records will be used or disclosed.

I agree to the use and disclosure of the health information of (Name) ______________________________
as described in this consent.

☐ I consent to having an unannounced home visit if SPOA Facilitator is unable to reach me by phone or mail.
☐ I Do Not consent to having an unannounced home visit if SPOA Facilitator is unable to reach me by phone or mail.

______________________________ ______________________________
Signature Date

____
Print Name

Request for Restriction of
Disclosures of Protected Health Information

I hereby request that Oswego County Mental Hygiene Division restrict disclosure of protected health information about ________________________________ (name of individual) in the manner described below.

☐ Please do not disclose protected health information to (name of person or organization).

____

____

☐ Please do not use protected health information for the purposes listed below, organization).

____

____

I understand that Oswego County Mental Hygiene Division will honor this request for restriction of use and disclosure of protected health information, unless an emergency situation requires disclosure for life safety reasons.

____

____ is the person who is the subject of the health records that will be restricted.

____ ____

Signature of Parent/Guardian Date

____

Print Name