F-740

Chemung County Department of Human Services
425-447 Pennsylvania Ave.
P.O Box 588
Elmira, NY 14902-0588

AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT NAME: _____ GENDER: _____ DOB: _____

ADDRESS: _____ TOWN/CITY: _____ ZIP: _____

Grants authority to: the ***Chemung County Department of Human Services,*** or a representative thereof, to obtain and release information to the following:

NAME/ADDRESS OF ORGANIZATION/AGENCY *OR* PERSON: _____

NATURE OF INFORMATION TO BE DISCLOSED:

*(check all that apply for Chemung County Department of Human Services, to **obtain** from or **release** to the above referenced agency or person)*

Obtain from	***Release to***	
☐	☐	Attendance and participation
☐	☐	Income/Government benefits (SNAP/TA/MA/HEAP)
☐	☐	Social Summary
☐		Diagnosis/progress/prognosis/discharge summary
☐		Educational (Academic or Special Education) records and evaluations
☐		Medical history/physical examination/treatment plans/referrals
☐		Mental health assessment/progress notes/treatment plans/discharge summary
☐		Substance abuse assessment/progress notes/treatment plans/discharge summary
☐		Psychological test results/projective assessments
☐		Test results/lab work/radiological studies/films
	☐	Other: _____

This form is used to authorize use or disclosure of an individual's protected health information for the purposes stated below:

☐ To provide ongoing case management services
☐ To provide and coordinate educational services
☐ To secure and/or maintain Public Benefits or employment
☐ To secure/maintain foster care or adoption certification
☐ To produce certified records and/or testify with a valid subpoena
☐ To allow for verbal/written communication
☐ To verify compliance with rules/codes/regulations/laws
☐ Other: _____

I understand that I have the right to refuse to sign this release, making it invalid and it will not affect my eligibility for benefits nor my right to services.

This information has been disclosed from records protected by Federal confidentiality rules, 42 CFR Part 2, as well as the Health Insurance Portability and Accountability Act of (HIPAA) of 1996. The recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law including but not limited to 42 CFR Part 2 and/or Section 33.13 of the NYS Mental Hygiene Law. If disclosed to someone who is not required to comply with federal privacy regulations, then it may be redisclosed and would no longer be protected.

I have a right to inspect and copy my protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR 164.524)

I, the undersigned, have read the above and authorize the disclosing agency/person named to disclose such information as herein contained. I understand that this authorization may be revoked by me at any time, in writing, except to the extent that action has been taken in reliance upon it. This authorization shall expire twelve (12) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply.

Time period, event or condition replacing period specified above: _____

Client signature: _____ Date: _____

Parent/Guardian/Personal Representative signature: _____ Date: _____

Witness signature: _____ Date: _____

Revised 05-20-22