Oswego County
Opportunities Inc.
Helping People. Supporting Communities. Changing Lives

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize:

Oswego County Opportunities, Inc, Mental Health Transitional Living
239 Oneida Street, Fulton, NY 13069 Phone: 315-598-9110 Fax: 315-598-631

to communicate and exchange information with:

____
Name of Provider

____
Address and Phone # of Provider

Regarding information from the record of:

Name: ________________________________ **DOB:** ____________

Information released will be limited to financial, psychiatric and medical. The purpose of disclosure of information is to be used in determining and verifying program and funding eligibility.

I understand that my records are protected under Federal Regulations governing Confidentiality and the Health Insurance Portability and Accountability Act (HIPPA) of 1996, 45 CFR Parts 160 and 164, and can not be disclosed without my written consent unless otherwise provided for in the regulations.
The duration of this authorization is 12 months. This authorization will expire 30 days after discharge, should I discharge from the OCO MHTL program during that time.
I understand that I may revoke this authorization at any time by notifying the program in writing, except to the extent that action has been taken in reliance on my consent.

________________________________ ____________
Signature of Applicant/Consumer Date

________________________________ ____________
Signature of Witness Date

____
Printed Name of Witness/Title

Residential Services Department
239 Oneida Street | Fulton, NY 13069
| ph: 315-598-9110 | fax: 315-598-6317
Mental Health Services / Family Care