TRINITY ASSISTANCE CORPORATION
AUTHORIZATION/CONSENT FOR DISCLOSURE OF CLINICAL INFORMATION

Use this form to get New York State consents or HIPAA authorization. (The Sharing Clinical Information Table describes when Mental Hygiene Law consent or a HIPAA authorization is needed.)

PART I. INDIVIDUAL INFORMATION	
NAME: LAST FIRST MI	DOB: Phone: ( )
ADDRESS:	City/State: ZIP:

Complete Part II to identify the organization disclosing clinical information, the organization receiving information, what information is being disclosed and for what purpose. Place a check in the appropriate box.

Part II. AUTHORIZATION FOR DISCLOSURE AND RECEIPT OF CLINICAL INFORMATION: By signing Part III of this form, the individual above authorizes the organization checked in A below to provide or receive protected information:	
Trinity Assistance Corporation 3545 Buffalo Rd, Rochester NY 14624 __Medicaid Service Coordination Program __FI/Self Directed Program __Respite __Community Habilitation __ ISS __Other: ____________________________	A. _x_ Name and Address of Service Provider/Organization Name:________________________________ Address:______________________________ City:__________________State: __________ Zip______________
Trinity Assistance Corporation 3545 Buffalo Rd, Rochester NY 14624 __Medicaid Service Coordination Program __FI/Self Directed Program __Respite __Community Habilitation __ ISS __Other: ____________________________	A. _x_ Name and Address of Service Provider/Organization Name:________________________________ Address:______________________________ City:__________________State: __________ Zip______________
Trinity Assistance Corporation 3545 Buffalo Rd, Rochester NY 14624 __Medicaid Service Coordination Program __FI/Self Directed Program __Respite __Community Habilitation __ ISS __Other: ____________________________	A. _x_ Name and Address of Service Provider/Organization Name:________________________________ Address:______________________________ City:__________________State: __________ Zip______________
Trinity Assistance Corporation 3545 Buffalo Rd, Rochester NY 14624 __Medicaid Service Coordination Program __FI/Self Directed Program __Respite __Community Habilitation __ ISS __Other: ____________________________	A. _x_ Name and Address of Service Provider/Organization Name:________________________________ Address:______________________________ City:__________________State: __________ Zip______________
Trinity Assistance Corporation 3545 Buffalo Rd, Rochester NY 14624 __Medicaid Service Coordination Program __FI/Self Directed Program __Respite __Community Habilitation __ ISS __Other: ____________________________	A. _x_ Name and Address of Service Provider/Organization Name:________________________________ Address:______________________________ City:__________________State: __________ Zip______________

TRINITY ASSISTANCE CORPORATION
AUTHORIZATION/CONSENT FOR DISCLOSURE OF CLINICAL INFORMATION

Part II. Continued.
Describe the information to be used or disclosed, including date(s) of service, type of service provided, etc.:
Dates of Service: _____

	Psychiatric Evaluation, reports, and Updates, Psychological, Neurological Evaluations, Assessments, Reports		All Treatment Plan, Treatment Program & Progress Reports Medical, Audiology, Ophthalmology, Dental, Reports/History, Assessments, Diagnostic, Immunization, Nursing, Medication Record, Summary of Hospitalization Reports
	All Medicaid Service Coordination Documents: Individual Service Plan (ISP)/Individual Family Support Plan, Social History, DDP1,2,4, LCED, NOD, Medicaid Service Coordination Progress Notes, SCORS Report, HCBS Waiver documents, plans, approvals, Habilitation Documents, reports, plans & progress notes, Social Services Documents & Reports		Occupational Therapy/Physical Therapy/ Dietary/ Speech/ Recreational Evaluations & Reports, Adaptive Behavior Scale
	All Educational Reports: Individualized Education Plan, Academic Performance		All HCBS Waiver Documents, Reports, plans & progress notes
	All information necessary to help facilitate a Person Centered Plan and subsequent Self Directed Plan.		Other: (Please specify)

Describe the Purpose of the disclosure:

X	For Treatment Purposes		Written Request for Information Attached
X	Documenting Eligibility	X	Linkage and Referral to Services
X	Service Planning		Other:

The following must be completed by health care providers or health plans requesting the authorization:
Will the health care provider or health plan requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health or clinical information described above?
_X_ NO ___ YES

Part III: below must be signed by the individual or his/her personal representative, and a copy of this signed from provided to the individual or representative.

Part III. SIGNATURE AND DATE	
1	I may revoke this authorization, in writing, at any time by notifying the person or entity I have authorized to use or disclose information as listed above.
2	I understand that a revocation is not effective against actions taken by the person or entity named above before they received such revocation and to the extent that they have relied upon this authorization.
3	I understand that if the person or entity authorized to receive my health and clinical information is not a health care provider or health plan, the released information may be disclosed and may no longer be protected by federal privacy regulations.
4	I may refuse to sign this form and my refusal to sign will not affect my ability to obtain treatment or payments except in some situations when such information is needed for payment and enrollment.
5	I may, in accordance with the OPWDD Privacy, inspect or copy any information used or disclosed under this authorization upon written request.

Signature of individual or representative	Date
Print Name of individual or representative	Representative's relationship to individual

This Authorization expires one year from the date of signature on: Date .