AUTHORIZATION FOR RELEASE OF INFORMATION	Name: Sex: M / F Date Of Birth: **Pathways Inc.** **Children & Family Treatment & Support Services**

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed:

Purpose or Need for Information:

1. This information is being requested:
   - □ by the individual or his/her personal representative; or
   - □ Other (please describe) _____
2. The purpose of the disclosure is (please describe):

TO FACILITATE ONGOING EVALUATION AND TREATMENT

To/From: Name, Address, & Title of Person / Organization/Facility/Program Disclosing Information	To/From: Name, Address, & Title of Person/Organization/ Facility / Program to Which this Disclosure is to be Made NOTE: If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.
Pathways Inc Children & Family Treatment & Support Svcs. 33 Denison Parkway West Corning, NY 14830	_____ _____ _____

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/ Program(s) identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and can not legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (insert name of facility/program) Pathways Inc. CFTSS Services
   I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the Pathways, Inc. CFTSS, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR S164.524).

B-1. One – Time Use/Disclosure: I hereby permit the one-time use or disclosure of the information described above to the person/ organization/facility/program identified above.

My authorization will expire:
- □ When acted upon;
- □ 90 Days fro this Date;
- □ Other _____

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Facility/Agency Name **Pathways Inc. CFTSS**	Patient's Name (Last, First, M.I.)	"C"/Id. No.

B-2. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/ organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:
□ When I am no longer receiving services from (insert name of facility/program) _____
□ One Year from this date:
□ Other _____

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

_____ _____
Signature of Patient or Medical Consenter Date

_____
Patient's Name (Printed)

_____
Medical Consenter's Name (Printed)

_____
Description of Medical Consenter's Authority to Act for the Patient (*required if Personal Representative signs Authorization*)

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY: _____
Staff person's name and title

Authorization Provided To: _____

Date: _____

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part 1, to the Person/Organization/Facility/ Program whose name and address is:

_____
_____
_____

I hereby refuse to authorize the use/disclosure indicated in Part 1, to the Person/Organization/Facility/Program whose name and address is:

_____
_____
_____

_____ _____
Signature of Patient or Medical Consenter Date

_____
Patient's Name (Printed)

_____
Medical Consenter's Name (Printed)

_____
Description of Medical Consenter's Authority to Act for the Patient (*required if Personal Representative signs Authorization*)