ERIE COUNTY DEPARTMENT OF SOCIAL SERVICES

AUTHORIZATION FOR RELEASE OF
PROTECTED PATIENT HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below to the Erie County Department of Social Services at 478 Main Street, Buffalo, New York 14202
I understand that:

1. This authorization is voluntary. I may revoke it at any time by notifying the DSS in writing except to the extent that action has been taken in reliance on it.
2. I understand that if the organization authorized to receive the information is not a health plan, health care provider or clearinghouse, the released information may no longer be protected by federal privacy regulations, except that an enrolee/patient may be prohibited from re-disclosing substance abuse information under the federal substance abuse confidentiality requirements.
3. State law governs the release of HIV/AIDS information and you may request a list of persons authorized to re-release HIV/AIDS information.
4. Authorizations for the release of HIV/AIDS data must comply with the requirements of Article 27-F of the Public Health Law.
5. Authorizations for the release of alcohol and substance abuse records must comply with the requirements of 42 C.F.R Part 2.

Released Information

This information may be released to and used by the Erie County Commissioner of Social Services or designee(s), and re-released by DSS to the Court and other Service Providers **for purposes of the investigation of a report of suspected child abuse or maltreatment, arranging for the provision of services and/or monitoring the client's compliance with court ordered services,** but only in connection with their official duties. This information may include, but is not limited to: diagnosis, care and treatment of medical and/or mental health history and treatment, completion or termination of treatment; medications; progress, attendance and degree of participation in any service or treatment program or components thereof as well as Court Ordered Service Plan compliance as mandated by the Court, as necessary to monitor my court-ordered Service Plan, and allow for its re-disclosure on an "as needed" basis.

I willingly and voluntarily authorize the disclosure of the following information:
(Please select all that apply)

Drug/Alcohol Treatment	
Medical Health	
Programs of the Erie County Health Department	
Court Ordered Services	
Mental Health Treatment/Counselling	
DSS Financial Assistance Programs	
DSS CPS and Foster Care Records	
Sexual Offender Treatment	
Parenting	
Vital Statistics – *(such as Birth Cert, Adoption Records, Military Discharge)*	
Employment Records	
Probation/Parole Status	
Other	

If selected 'Other', please provide details in space below

I authorize the disclosure of all school documentation *(This includes all attendance and duality sharing of information as it relates to the best interest of the child)* ☐

Disclosure Purpose
The sole purpose and need to disclose the previously provided information is to allow the Department of Social Services, the Court and other Service Providers to monitor my voluntary participation in services, or where there have been court proceedings, my compliance with the conditions of my court mandate to engage in remedial services, as directed through the Court Ordered Service Plan, and my consent for release of such information is limited to these purposes.

Signature

_____ _____

Client Signature Date