



FRANCES V. LANIGAN
Commissioner

OSWEGO COUNTY BUILDING
100 SPRING STREET, PO BOX 1320
MEXICO, NEW YORK 13114

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**Adult Mental Health - Single Point of Access (SPOA)
CONSENT FOR RELEASE OF INFORMATION**

I consent to use and disclosure of protected health information about me for arranging services, treatment, payment, and health care operations as described below. This means that information about my health will be used by the staff of Oswego County Mental Hygiene Division or disclosed to other people or organizations whenever needed to:

- Provide services to me or arrange for services by another health care or mental health service provider.
- Arrange for payment for services to me.
- Operate the business of Oswego County Adult Mental Health Single Point of Access
- Enable Oswego County Mental Hygiene Division to review the quality and appropriateness of care I receive from mental health organizations that provide services to me.

I understand that information I choose to disclose pursuant to this consent may be re-disclosed by the recipient of the information. Most health care providers and all health benefit plans are obligated to follow federal rules and state laws for protection of the privacy of your health information. But those rules and laws do not apply to all organizations.

I understand that there is no time limit on this consent.

I also understand that I may revoke this consent at any time.

I am the person who is the subject of the health records that will be used or disclosed. I agree to use and disclosure of my health information as described in this consent.

Signature

Date

Print Name

I am the personal representative of the person whose records will be used or disclosed.

My relationship to that person is _____ .

I agree to use and disclosure of the health information of (Name) _____ as described in this consent.

Signature

Date

Print Name

**Request for Restriction of
Disclosures of Protected Health Information**

I hereby request that Oswego County Mental Hygiene Division restrict disclosure of protected health information about _____ (name of individual) in the manner described below.

Please do not disclose protected health information to (name of person or organization).

Please do not use protected health information for the purposes listed below, (organization).

I understand that Oswego County Mental Hygiene Division will honor this request for restriction of use and disclosure of protected health information, unless an emergency situation requires disclosure for life safety reasons.

I am the person who is the subject of the health records that will be restricted.

Signature

Date

Print Name

I am the personal representative of the person whose records will be restricted. My relationship to that person is _____.

I agree to the restriction on the use of the health information as described in this request.

Signature

Date

Print Name