

**CONSENT FOR RELEASE OF INFORMATION
CONCERNING
ALCOHOLISM/DRUG ABUSE PATIENT**

PATIENT'S LAST NAME	FIRST	M.I.
CASE NO.		
FACILITY		UNIT

INSTRUCTIONS: GIVE A COPY OF THE FORM TO THE PATIENT! Prepare one (1) copy for the Patient's Case Record. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

**[DISCLOSURE]/ [RELEASE] WITH PATIENT'S CONSENT
(CIRCLE)**

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

I consent to the disclosure to and between the New York State Department of Health (DOH) and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) of my entire Medicaid claim data for the purpose of identifying whether I am eligible to participate in a voluntary case management program, entitled Managed Addiction Treatment Services (MATS). I understand that MATS is a voluntary program that will assist me in obtaining appropriate medical and non medical care that I need to overcome my addiction, while helping me ensure that I am not getting services that I do not need. I also understand that I will be assigned a case manager who will work with me to ensure that appropriate services are available. I further understand that the MATS program is free, and that I may disenroll at any time. I also consent to being contacted by OASAS or their designated agent, in a confidential manner, solely for the purpose of being offered an opportunity to voluntarily participate in the MATS program.

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

This release will permit OASAS to identify individuals who may be eligible to benefit from voluntary participation in the MATS program.

NAME OF PERSON OR TITLE OF ORGANIZATION
DISCLOSING/RELEASING INFORMATION

NAME OF PERSON OR TITLE OF ORGANIZATION TO WHICH THE
DISCLOSURE/RELEASE IS TO BE MADE

Between: New York State Department of Health

And: New York State Office of Alcoholism & Substance Abuse Services

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named above to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire five (5) years from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above:

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NOTE: Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TR-1 [A-4400])

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

(Signature of Patient)

(Signature of Parent/Guardian, when required)

(Print Name of Patient)

(Print Name of Parent/Guardian)

(Date)

(Date)