



Community Services Department
St. Lawrence County
Assisted Outpatient Treatment

99 West Main Street, Gouverneur, NY 13642
Phone: (315) 386-2137 Fax: (315) 287-0285

INFORMATION RELEASE AUTHORIZATION

(See Reverse Side for Instructions)

NAME: _____ DOB: _____

Part I - Consent To Release Information

For the purpose of AOT, I authorize Lindsay Best to:

obtain from [] provide to []

(person or agency)

(address)

the following information:

- Treatment Summary & Recommendations
Psychiatric Evaluation
Social/Family History
Physical/Medical History
Psychological Testing
Past & Current Agency/School Involvement
Other (Specify)

This information will be used for the following purpose(s):

- Evaluation and Continuing Treatment
AOT Program Eligibility
Coordinating Care
Other (specify)

Check either A or B

A. [] I hereby authorize the periodic release of the above information to the person, organization facility, or program identified above as often as necessary to plan for/provide care and treatment. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time.

My consent to release information to the person, organization, facility or program identified above will expire when I am no longer receiving services from such person, organization, facility or program, or one year from this date, whichever occurs first.

B. [] I hereby authorize the one-time release of the above information to the person, organization, facility, or program identified above. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time.

My consent to release information will expire when acted upon, or 90 days from this date, whichever occurs first.

Signature of Client/Person Acting for Client

Relationship

Date

Signature of Witness

Title

Date



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Part II-Cancelation/Refusal to Release Information

I hereby cancel my permission to release information indicated in Part I, to the person, organization, facility, or program whose name and address is:

I hereby refuse to authorize the release of information indicated in Part I to the person, organization, facility, or program whose name and address is:

Signature of Client/Person Acting for Client

Relationship

Date

Signature of Witness

Title

Date

INSTRUCTIONS

1. Client signs A if information is to be released periodically during an episode of treatment.
2. Client signs B if the release of information is for a single event.