SPOA SUPPORTIVE HOUSING
AUTHORIZATION FOR RE-RELEASE OF INFORMATION

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 Re-Release Information

Description of Information to be Used/Disclosed:

You are being referred for Supportive Housing for adults with a serious mental illness. In order to expedite your application, the Center for Urban Community Services (CUCS), New York City's Adult Single Point of Access (SPOA) program must obtain and review your HRA 2010e application packet, which includes your psychiatric and psychosocial evaluations from your referral source. CUCS needs this information to help determine the right housing option for you, based on your needs and preferences. Once you are determined eligible by Human Resource Administration (HRA) for this type of supportive housing, your HRA 2010e packet will be sent to CUCS by the facility/agency that completed the application. CUCS will then need to share your information with the appropriate supportive housing agency that is contracted through the New York State Office of Mental Health and/or New York City Department of Health and Mental Hygiene. The information included in the HRA 2010e application packet that will need to be shared with the Supportive Housing Agency includes all of the following:

☐ The HRA 2010e application and determination letter

☐ A current psychosocial summary, completed within the last 6 months

☐ A current psychiatric evaluation, signed and dated by a Licensed Psychiatrist, Licensed Clinical Social Worker, Licensed Psychologist, or a Licensed Psychiatric Nurse Practitioner within the last 6 months

☐ TB results completed in the past year

Your mental health information is protected by federal and state law (the Health Insurance Portability and Accountability Act of 1996, or "HIPAA", and New York State Mental Hygiene Law Section 33.13). If your referral source is an alcohol or drug treatment program that received federal funds, this information is protected by federal regulations at 42 CFR Part 2. This means your referral source cannot share your information with CUCS without your written consent, and CUCS also needs your permission in order to share that information with the assigned Supportive Housing Agency. On this authorization form, you are being asked to consent to have your psychiatric and psychosocial evaluations released by your referral source to CUCS. You are also being asked to consent to have your HRA 2010e application packet, which includes your psychiatric and psychosocial evaluations, released by your referral source to CUCS, for the purpose of making appropriate referrals to supportive housing. You are also being asked to consent to have CUCS re-release the information included in your HRA 2010e application packet to the Supportive Housing agency that will be interviewing you to determine whether you are eligible for the housing and services it offers.

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):

I understand that my HRA 2010e application packet, including my psychosocial and psychiatric evaluations, that is provided by my referral source, ____________________________________ will be used by CUCS to provide the social worker/case worker/discharge planner/pre-release coordinator who is assisting me with my housing search, with possible referrals to Supportive Housing. When CUCS receives the HRA packet from my worker, they will share information in my HRA 2010e application packet (that includes the items listed above) with the appropriate Supportive Housing Agency that will be interviewing me to determine if I am eligible for the housing and services it offers.

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A. I authorize CUCS, the New York City's Adult SPOA Housing program to review my HRA 2010e application, including my psychosocial and psychiatric information, provided by my referral source in order to make recommendations for the appropriate level of housing. If I am approved by HRA for Supportive Housing, I also authorize CUCS to use and disclose certain information in my HRA 2010e application packet (that includes the items listed above on this form) to the appropriate supportive Housing agency for the purpose of determining if I am eligible for the services it offers. 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 cannot 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 re-disclosed and would no longer be protected. However, if my information is also protected by Mental Hygiene Law Section 33.13 or 42 CFR Part 2, it cannot be redisclosed unless I give my permission or the redisclosure is otherwise permitted by such law or regulation.
4. I have the right to revoke (take back) this authorization at any time, by writing to CUCS, the New York City Adult Single Point of Access. I am aware that 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 New York State Office of Mental Health, 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§164.524.

B. **Periodic Use/Disclosure:** I hereby permit the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as necessary to fulfill the purpose identified above. I hereby understand that I have the right to revoke my authorization to release information by writing the New York City Adult Single Point of Access at:

NYC Adult Single Point of Access for Housing (SPOA)
Center for Urban Community Services
198 East 121 Street, 6th Floor
New York, New York 10035

I understand that this authorization will expire when I am no longer being considered for the Supportive Housing from the agency that I have been referred to by CUCS, the NYC Adult Single Point of Access.

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C. Patient Signature: I have been given the opportunity to ask questions if I do not understand any of the information on this form. I certify that I authorize the use of my medical/mental health information as set forth in this document.

Signature of Patient or Personal Representative ______________________ Date ____________

Patient's Name (Printed) ______________________

Personal Representative's Name (Printed) ______________________

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

D. 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 CUCS SPOA Housing Program

Authorization Provided To ______________________ (Health Home)

Authorization Provided To ______________________ (Health Insurance Provider)

Date ______________________

To be Completed by Facility:

Signature of Staff Person Using/Disclosing Information ______________________

Title ______________________

Date Released ______________________

PART 2: Revocation of Authorization to Re-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:

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

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Signature of Patient or Personal Representative ______________________ Date ____________

Patient's Name (Printed) ______________________

Personal Representative's Name (Printed) ______________________

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