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 Newvine 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

_____ _____ _____

04/21

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Signature of Witness | Title | Date

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.

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