

**DELAWARE COUNTY NY CONNECTS: CHOICES FOR LONG TERM CARE**



**Lead Agencies:**  
**Delaware County Office for the Aging**  
**Department of Social Services**  
**Public Health Department**

**RELEASE OF/REQUEST FOR CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_, (Patient/Client/Legal Representative) [164.508(c)(1)(ii)]  
**(if authorizer is a legal representative, attach a copy of the document that proves your legal right to release)** hereby consent to and authorize Delaware County NY Connects (Delaware County Department of Social Services; Delaware County Public Health Nursing Service; Delaware County Office for the Aging); and my Provider Agencies to disclose to or request from information regarding my case/the case of:

Name: \_\_\_\_\_ [164.508 (c)(1)(iii)]

Address: \_\_\_\_\_ [164.508 (c)(1)(iii)]

I understand the purpose of the disclosure is for planning and coordination of necessary services. [164.508(c)(1)(iv)]

Covering the period (s) of healthcare from (date): \_\_\_\_\_ to (date): \_\_\_\_\_ [164.508(c)(1)(i)]

I understand the information may/will include data obtained during service screening and could include details regarding my/his/her medical condition. Information to be used or disclosed (describe): [164.508(c)(1)(I)]

**Medical History/Diagnosis; Physical, Mental & Medical Limitations; Medications.**

I understand that only the minimum amount of health information necessary to achieve the purposes of the disclosure will be released and only for the dates authorized above.

I understand that I can revoke this authorization in writing at any time, except to the extent that action was already taken based upon the original authorization. [164.508(c)(2)(i)(A-B)]

Unless otherwise revoked, this authorization will expire in one year from signature. \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(enter expiration date)  
[164.508(c)(1)(v)]

I understand the Agency cannot condition my continued or future treatment on whether I provide authorization for the requested use or disclosure and that I can refuse to sign this authorization. [164/508(c)(2)(ii)(A-B)]

As allowed by law, the Agency is entitled to receive payment for the administrative costs incurred when fulfilling a request to copy records.

**DELAWARE COUNTY NY CONNECTS: CHOICES FOR LONG TERM CARE**



**Lead Agencies:**  
**Delaware County Office for the Aging**  
**Department of Social Services**  
**Public Health Department**

**RELEASE OF/REQUEST FOR CONFIDENTIAL INFORMATION**

I understand the information used or disclosed as a result of this signed document may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

**[164.508(c)(2)(iii)]**

\_\_\_\_\_  
(Signature of Patient/Client)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)

**[164.508(c)(1)(ii)]**

\_\_\_\_\_  
(Signature of Legal Representative)

\_\_\_\_\_  
(Description of Legal Reps. Authority)

**[164.508(c)(1)(vi)]**

\_\_\_\_\_  
(Signature of the witness)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)