# Maximizing Independent Living Choices, Inc.

**St. Lawrence County**
156 Center Street
Massena, NY 13662
(315) 764-9442 Phone
(315) 764-9464 Fax

www.milcinc.org

**Jefferson/Lewis County**
156 Center Street
Massena, NY 13662
(315) 705-3834 Phone
(315) 222-7442 Fax

## Referral Form

**Referral Date:** _____

**Referral Source:** _____ **Referral Phone:** _____

**Name:** _____ **Contact Phone:** _____

**Address:** _____

**Over 65** ☐ **Disabled** ☐ **Blind** ☐

**Power of Attorney/Guardian:** _____ **Phone:** _____

**Services Requested – Jefferson County**

___ **Medicare Savings Plan**
___ **Medicaid – Community Plan**
___ **Medicaid – Managed Long Term Care**
___ **Medicaid – Nursing Home**
___ **Medicaid – Working Disabled**
___ **Consumer Directed Personal Assistance Program**

**Services Requested – Lewis County**

___ **Medicare Savings Plan**
___ **Medicaid – Community Plan**
___ **Medicaid – Managed Long Term Care**
___ **Medicaid – Nursing Home**
___ **Medicaid – Working Disabled**
___ **Consumer Directed Personal Assistance Program**

A two-way release must accompany the referral before an employee of MILC/WNYIL can contact the consumer

**Signature:** _____ **Date:** _____

**Western New York Independent Living, Inc.**
**3108 Main Street, Buffalo, NY 14214**
**Phone: (716) 836-0822 www.wnyil.org**

# INDIVIDUAL AUTHORIZATION FOR THE EXCHANGE, USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Consumer Name: _____Consumer Date of Birth: _____

*WNYIL, Inc. understands that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we use or disclose your protected health information for the purposes described below. This form provides that authorization and helps make sure that you are properly informed of how this information will be used or disclosed. Please read and complete the information below carefully before signing this form.*

**I, or my authorized representative, hereby authorize the use or disclosure of protected health information as follows:**

___One-Way, information shared by Person/Organization #1 to WNYIL, Inc (#2)
___ Two-Way, information shared **between both** #1 MILC/WNYIL, INC and #2 Person/Organization

| **# 1 Person/Organization: MILC/WNYIL** | | **# 2 Person/Organization:** | |
|---|---|---|---|
| **Name** | Patti Mothersell | **Staff Name** | |
| **Title** | FE | **Staff Title** | |
| **Address** | PO Box 816 | **Address** | |
| | Adams Center, NY 13606 | | |
| **Phone** | 315-705-3834 | **Phone** | |
| **Fax** | 315-222-7442 | **Fax** | |

**The information that may be used or disclosed is listed below. Initial all that apply; if you do not want all records in a given category shared, please indicate specific records on the lines provided.**

_____ **Medical Records: _____**
(initials) _____

_____ **Behavioral Health Records:_____**
(initials) _____

_____ **Drug and Alcohol Treatment Records: _____**
(initials) _____

_____ **Other *specific* records/information:** Release of name, address/phone, application,
(initials) documents, and statements to determine eligibility for Medicaid

**The purpose of this disclosure is to provide/receive collateral information and facilitate coordination of health service activities for the above named consumer.**

**Expiration Date: _____**

**Specific Understandings:**

- By signing this authorization form, I authorize the exchange, use or disclosure of my health information protected by the federal health privacy law 45 CFR parts 160, 164, as described above.
- I understand that if I authorize the release of behavioral health information the disclosing party named above will disclose such information in accordance with Sections 331.13 and 33.16 of the Mental Hygiene Law; and if I authorize the release of drug and alcohol treatment records the disclosing party names above will disclose such information in accordance with federal alcohol and drug record privacy regulations (42 CFR Part 2).
- I understand that if I am authorizing the release of alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.
- I understand this form is NOT for releasing HIV-AIDS related health information. If I wish to release HIV-related health information I need to fill out a separate release form.
- I understand that I do not have to allow release of my health information, and that I can change my mind and revoke my authorization at any time, except to the extent that WNYIL, Inc. has already taken action based upon your authorization. To revoke this authorization, please write to WNYIL, Inc. Intake Office, 3108 Main Street, Buffalo, New York 14214.

**SIGNATURE:** *I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.*

_____ _____

Print Name of Consumer or Authorized Representative (Representative Date of Birth, if applicable)

_____ _____

Signature of Consumer or Authorized Representative Date

Description of Authorized Representative's Authority (if applicable): _____

_____

***THE CONSUMER OR HIS/HER AUTHORIZED REPRESENTATIVE HAS THE RIGHT TO BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.***