Version 4.0 – November, 2018

MONROE COUNTY DEPARTMENT OF HUMAN SERVICES
RAPID ENGAGEMENT DELIVERY (RED) PROGRAM

CONSENT TO USE AND DISCLOSE INFORMATION

CLIENT NAME: _____ _____ _____
Last First Middle

DATE OF BIRTH: _____ Last 4 digits of SS#: _____

I am interested in receiving services from the ***Monroe County RED Program***. In order to assess my eligibility for the program, I give permission to the organizations listed below to disclose information about my substance use and mental health treatment to the Monroe County Department of Human Services – Office of Mental Health, the Monroe County Single Point of Access (SPOA), the RED program, the Monroe County Recovery Connection Program, and Coordinated Care Services, Inc.

Liberty Resources
Monroe County Pre-Trial Services
Strong Memorial Hosp./University of Rochester
Helio Health
Catholic Family Center
Conifer Counseling
Mc Collaborative
Person Centered Housing Options
Evelyn Brandon Health Center
Rochester Regional Health System
Veteran's Outreach Center
Huther-Doyle
John L. Norris Clinic
Monroe County Treatment Courts

This information may include: my diagnosis, medical assessments, mental health evaluations, substance use evaluations, psychosocial assessments, results of lab work, recovery plans, discharge summaries, treatment recommendations, progress notes and billing information.
In addition, I understand that the Monroe County Care Coordination (RED) Program will release information to Coordinated Care Services, Inc. to use in evaluating the effectiveness of the program.

This permission expires when my referral to the RED program has been closed or I am no longer receiving services from this program.

I have read and understand the above permission statements, and I authorize the disclosure of the information described above. I understand that this consent may be withdrawn by me, with notice, at any time except to the extent that action has already been taken relying upon the consent. In all cases, this release shall expire when my referral to the Monroe County Care coordination services has been closed or I am no longer receiving services from this program. I understand that the disclosure is bound by Title 42 CFR Part 2 governing the confidentiality of client records and that redisclosure of this information to any party other than indicated in this consent is prohibited without additional written authorization by me. I have the right to cancel my authorization at any time before the information is released.

Client Signature: _____

Date: _____

I hereby cancel my authorization to release the information outlined on this form.

Client Signature: _____ Date: _____