

**Catholic Charities of Cortland County**  
**Lawrence House Community Residence and Treatment Apartments Referral**

The Lawrence House is a 24-hour supervised community residence located close to downtown Cortland. Licensed by the NYS Office of Mental Health, the program serves adults 18 years and older as they transition toward independent community living from higher levels of care, such as hospitals or other inpatient settings. Lawrence House is known for having expertise working with individuals who live with co-occurring mental health and substance use concerns.

The Treatment Apartment Program offers limited supervised living in scattered-site apartments. It is a step toward independent living for those who are transitioning out of a higher level of care. Clients are expected to make positive efforts in treatment, must be capable of self-administering medications, maintaining their apartment, abide by landlord and agency rules, and attend all necessary appointments. Clients agree to meet regularly with their assigned residential counselor to develop meaningful and realistic goals that advance recovery and lead to independent living.

**REFERRAL SOURCE**

Contact Name: \_\_\_\_\_ Agency, if applicable: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**CLIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Address \_\_\_\_\_ Phone: \_\_\_\_\_

Current Living Situation: \_\_\_\_\_

Female     Male

Has this client been referred to us before?     Yes     No     Unknown

If yes, please explain: \_\_\_\_\_

Client is seriously and persistently mentally ill?     Yes\*     No

*\*SPMI Form must accompany referral*

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**FINANCIAL STATUS**

Client currently receives:     SSI     SSD     VA Benefit     Wages

SSI/SSD Pending     PA - County of origin: \_\_\_\_\_

Current Caseworker: \_\_\_\_\_ Caseworker Phone: \_\_\_\_\_

Medicaid # \_\_\_\_\_  Medicare     Private Ins.: \_\_\_\_\_

Current Representative Payee \_\_\_\_\_ Payee Phone: \_\_\_\_\_

Applicant does not currently have, but needs, representative payee services.

Has the client ever been sanctioned by DSS?     Yes\*     No

\*If yes, explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**CURRENT FINANCIAL OBLIGATIONS**

List all appropriate bills and amounts

Rent/Housing	_____	Heat	_____	Electricity	_____
Phone	_____	Other Utilities	_____	Food	_____
Child Support	_____	Alimony	_____	Fines/Restitutions	_____
Other	_____	Other	_____	Other	_____

**MEDICAL STATUS**

Does client have any medical conditions that we should be aware of? (i.e. seizures, allergies, special diet, visual impairment, limited impairment, chronic illness, etc.)

Yes       No

If yes, explain: \_\_\_\_\_

Client's Prescriber(s) Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Is client capable of self-preservation in case of emergency? (Evacuating housing safely)

Yes       No

**BEHAVIORAL HEALTH HISTORY**

Indicate history of the following, as appropriate:

Suicide attempts	Date(s): _____	Inappropriate sexual behavior	Date(s): _____
Suicidal threats	Date(s): _____	Self-injurious behavior	Date(s): _____
Fire setting	Date(s): _____	Crises requiring frequent readmission	Date(s): _____
Violence	Date(s): _____	Noncompliance with appts. and/or meds	Date(s): _____
Assault	Date(s): _____	Substance Use	Date(s): _____

If checked, provide brief detail: \_\_\_\_\_

**SERVICE UTILIZATION**

Indicate current/past services used; supply dates and providers, if known.

Inpatient treatment: \_\_\_\_\_

Outpatient treatment: \_\_\_\_\_

OPWDD Services: \_\_\_\_\_

Care Coordination: \_\_\_\_\_

Other: \_\_\_\_\_

Describe past situations precipitating hospitalizations or professional interventions \_\_\_\_\_

**HOUSING**

Check if applicant has experienced. If checked, give date and location.

- Homelessness \_\_\_\_\_
- Group home/Community Residence (OMH) \_\_\_\_\_
- Group home/Community Residence (OASAS) \_\_\_\_\_
- Other Supported or Supervised Living Environment \_\_\_\_\_
- Independent Living, alone \_\_\_\_\_
- Independent Living, with others \_\_\_\_\_
- Supported Housing Assistance \_\_\_\_\_
- Section 8 Application and/or Subsidy \_\_\_\_\_
- Evictions? If yes, please explain: \_\_\_\_\_

**VOCATIONAL**

Check applicant's experience. If checked, give dates and locations.

- |  |   |
|--|---|
| <input type="checkbox"/> Highest Grade Level Completed _____ | <input type="checkbox"/> GED _____            |
| <input type="checkbox"/> Sheltered Workshop _____            | <input type="checkbox"/> College Degree _____ |
| <input type="checkbox"/> Supported Employment _____          | <input type="checkbox"/> VESID _____          |
| <input type="checkbox"/> Vocational Training _____           | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Special Education _____             |   |
| <input type="checkbox"/> Competitive Employment _____        |   |

**CRIMINAL JUSTICE SYSTEM**

Check if current or past history of the following - Provide name of Probation/Parole Officer if current.

- |  |  |
|--|--|
| <input type="checkbox"/> Probation _____             | <input type="checkbox"/> Charges Pending _____ |
| <input type="checkbox"/> Parole _____                | <input type="checkbox"/> CPL Date _____        |
| <input type="checkbox"/> Conviction of a Crime _____ |  |

Provide Details: \_\_\_\_\_

**FAMILY, SOCIAL & COMMUNITY SUPPORTS**

Check applicant's current supports and note names when possible.

- Family \_\_\_\_\_
- Friends \_\_\_\_\_
- Religious \_\_\_\_\_
- Support Groups \_\_\_\_\_
- Care Coordinator \_\_\_\_\_

**COMMUNITY LIVING/NEEDS**

Check needed Services.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Outpatient Treatment | <input type="checkbox"/> Transportation     | <input type="checkbox"/> Connection to a Psychiatrist |
| <input type="checkbox"/> Psychosocial Rehab   | <input type="checkbox"/> Family Support     | <input type="checkbox"/> Care Coordination            |
| <input type="checkbox"/> General Health Care  | <input type="checkbox"/> Financial Guidance | <input type="checkbox"/> Friends or Social Needs      |
| <input type="checkbox"/> Housing (OMH)        | <input type="checkbox"/> Other _____        |   |

**CLINICAL ASSESSMENT**

**ICD 10 Code**

**Diagnosis**

Principal Diagnosis \_\_\_\_\_

(Must be a mental health diagnosis)

Note any recommendations, or focus of treatment, and why this level of care may be appropriate?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS**

List all medications used or attach a copy of a current medication list.

<u>Medication</u>	<u>Dosage</u>	<u>Prescribing MD</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is client capable of self-administration of medications?  Yes  No

What does the client think about living in this residential setting?

What are the strengths (skills/personal resources that can be used in this residential setting?)

Are there any areas which might be challenging (i.e., expectations, responsibilities, staff supervision, living with others?) \_\_\_\_\_

Is the individual willing to share a bedroom? Ever shared a bedroom before? \_\_\_\_\_

What program is the individual more interested in? \_\_\_\_\_

~~~~~  
***Include the following with this completed referral:***

- Physical Assessment
- Psychosocial Assessment
- Physician Authorization Form
- Current medication list

**PLEASE SEND REFERRALS VIA ONE OF THE FOLLOWING METHODS:**

**Fax:** (607) 299-4800

**Secure e-mail:**  
pchevallard@ccocc.org

**Mail:**

Catholic Charities of Cortland County  
ATTN: LH/TAP Program Manager  
33-35 Central Avenue  
Cortland, New York 13045

**Catholic Charities of Cortland County**  
**33-35 Central Avenue**  
**Cortland, NY 13045**

Service Authorization for Restorative Services  
Pursuant to Part 593 of 14 NYCRR

**Initial Authorization (MD ONLY)**  
(Initial must be "face to face")

**Client's Name:** \_\_\_\_\_ **Medicaid CIN:** \_\_\_\_\_

**Program:** \_\_\_\_\_

The above named individual has been referred to a Catholic Charities of Cortland County residential treatment program. To be eligible for rehabilitation services in the community residence, a physician must authorize services in writing based upon clinical information and a face-to-face assessment for the individual prior to admission.

Based on this face-to-face assessment, please complete the following information and return for authorization of rehabilitative services.

**Principal Diagnosis:** \_\_\_\_\_ **ICD 10 Code:** \_\_\_\_\_

I, the undersigned

Licensed Physician (**Initial Authorization must be signed by MD**)

based on my assessment and clinical records available to me, have determined that the above named client would benefit from the provision of the mental health restorative services defined pursuant to part 593 of 14 NYCRR.

**Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**NPI #:** \_\_\_\_\_ **License #:** \_\_\_\_\_

\*Authorization Expiration:  
Lawrence House: 6 months from date of signature.  
Treatment Apartments: 1 year from date of signature

**NYS OMH - SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI) This form must be completed by a licensed clinician or other mental health professional. Information may be requested from collateral sources.**

**Client Name:** \_\_\_\_\_

In order to be considered an adult with Serious and Persistent Mental Illness (SPMI), the individual must meet criteria in “1” *and* either “2” *or* “3” *or* “4” as defined below.

**Circle the answer that applies**

**1. Designated Mental Illness**

The individual is at least 18 years of age and currently meets the criteria for a psychiatric diagnosis, according to DSM 5.

Yes

No

Principal Diagnosis: \_\_\_\_\_

DSM 5 Code: \_\_\_\_\_

ICD-10 Code: \_\_\_\_\_

**AND**

**2. SSI or SSDI due to Mental Illness**

The individual is currently receiving SSI/SSDI due to a designated mental illness.

Yes

No

**OR**

**3. Extended Impairment in Functioning due to Mental Illness:**

The individual has experienced **two** of the following **four** functional limitations due to a designated mental illness **over the past 12 months** on a continuous or intermittent basis:

a.) Marked Difficulties in Self-Care

i.e.: personal hygiene, diet, clothing, avoidance of injury, securing appropriate health care and/or compliance with medical advice

Yes

No

b.) Marked Restriction of Activities of Daily Living (ADLs)

e.g.: maintaining a residence, using transportation, day-to-day money management, accessing community services

Yes

No

c.) Marked Difficulties in Maintaining Social Functioning

e.g.: establishing and maintaining social relationships; interpersonal interactions with primary partner, children or other family members, friends, and/or neighbors; social skills; compliance with social norms; appropriate use of leisure time

Yes

No

d.) Frequent Deficiencies of Concentration, Persistence or Pace, Resulting in Failure to Complete Tasks in a Timely Manner

i.e.: inability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings; individuals may exhibit limitations in these areas when they are repeatedly unable to complete tasks or require assistance in the completion of tasks

Yes

No

**OR**

**4. Reliance on Psychiatric Treatment, Rehabilitation and Supports**

The individual has a documented history showing that, at some time prior, he/she met the threshold for “3” (above), but his/her symptoms and/or functioning problems are currently attenuated by medication and/or psychiatric rehabilitation and supports.\*

Yes

No

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Title:** \_\_\_\_\_

\***Medication** refers to psychotropic medications, which may control certain primary manifestations of mental disorder (e.g. hallucinations), but may or may not affect functional limitations imposed by the mental disorder. **Psychiatric rehabilitation and supports** refer to highly structured and supportive settings (e.g. congregate or apartment treatment programs), which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder.

|                                                     |                                                         |                                                             |
|-----------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------|
| <b>AUTHORIZATION FOR<br/>RELEASE OF INFORMATION</b> | Patient's Name (Last, First, M.I.)                      | "C" No.                                                     |
|                                                     | Sex                                                     | Date of Birth                                               |
|                                                     | Facility Name:<br>Catholic Charities of Cortland County | Unit/Ward: Lawrence House &<br>Treatment Apartments Program |

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information (for other than treatment, payment, or health care operations purposes), 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 Release Information**

Description of Information to be Used/Disclosed:

|                                                   |                                                         |                                                  |                                               |                                               |
|---------------------------------------------------|---------------------------------------------------------|--------------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Contact Information      | <input type="checkbox"/> Current Medications            | <input type="checkbox"/> Current Services        | <input type="checkbox"/> Daily Living Skills  | <input type="checkbox"/> Diagnosis            |
| <input type="checkbox"/> Education                | <input type="checkbox"/> Entitlements                   | <input type="checkbox"/> Emergency Contact Info. | <input type="checkbox"/> Functional Abilities | <input type="checkbox"/> Mental Health Status |
| <input type="checkbox"/> Psychosocial information | <input type="checkbox"/> Characteristics/<br>Photograph | <input type="checkbox"/> Electronic Files        |                                               |                                               |

Other: \_\_\_\_\_

**Purpose or Need for Information:**

1. This information is being requested:

by the individual or his/her personal representative; or

Other (please describe) Catholic Charities (Cortland County)

2. The purpose of the disclosure is (please describe)

|                                                 |                                              |                                            |                                                |
|-------------------------------------------------|----------------------------------------------|--------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Screening/Assessment   | <input type="checkbox"/> Bill Insurance      | <input type="checkbox"/> Emergency Contact | <input type="checkbox"/> Emergency Services    |
| <input type="checkbox"/> Establish Entitlements | <input type="checkbox"/> Establish Services  | <input type="checkbox"/> Housing           | <input type="checkbox"/> Coordinating Services |
|                                                 | <input type="checkbox"/> Electronic Database |                                            |                                                |

Other: \_\_\_\_\_

Exchange of Information, in either direction, between the parties below  
(Include: Name, Address, Title of person/Organization/Facility/Program)

|                                                                                                                                                                                 |                |                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Catholic Charities of Cortland County</b><br>Residential & Housing Services<br>33-35 Central Avenue<br>Cortland, New York 13045<br>Phone: (607) 756-5992 Fax: (607) 299-4800 | (Two Way)<br>⇄ | <b>Admissions Committee:</b> Including representatives from Family & Children's Counseling Services, Cortland County Mental Health Clinic, Cortland City Police Department, Guthrie Cortland Medical Center, Cortland County Probation Department |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. 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.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by Catholic Charities shown below. I am aware that my 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-1. One-Time Use/Disclosure:** I hereby permit the one-time use or disclosure of the information described above between the person(s)/organization(s)/facility(s)/program(s) identified above.

My authorization will expire:

When acted upon;

90 Days from this Date;

Other: \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                    |             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------|
| Facility/Agency Name<br>Catholic Charities (Cortland County)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Patient's Name (Last, First, M.I.) | "C"/ID. No. |
| <p>B-2. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above between the person(s)/organization(s)/facility(s)/program(s) identified above as often as necessary to fulfill the purpose identified above.</p> <p>My authorization will expire:</p> <p><input type="checkbox"/> When I am no longer receiving services from: <u>Lawrence House &amp; Treatment Apartments Program</u></p> <p><input type="checkbox"/> One year from this date      <input type="checkbox"/> Other: _____</p> |                                    |             |
| <p>C. <b>Patient Signature:</b> I certify that I authorize the use of my health information as set forth in this document.</p>                                                                                                                                                                                                                                                                                                                                                                                                                    |                                    |             |
| 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 <i>(required if Personal Representative signs Authorization)</i>                                                                                                                                                                                                                                                                                                                                                                                                        |                                    |             |
| <p>D. <b>Witness Statement/Signature:</b> 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.</p> <p>WITNESSED BY: _____</p> <p style="padding-left: 150px;">Staff person's name and title</p> <p>Authorization Provided to: _____</p> <p>Date: _____</p>                                                                                                                                                            |                                    |             |
| <p><i>To be Completed by Facility:</i></p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Signature of Staff Person Using/Disclosing Information</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Title <span style="float: right;">Date Released</span></p>                                                                                                                                                                                                                                  |                                    |             |
| <b>PART 2: Revocation of Authorization to Release Information</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                    |             |
| <p>I hereby revoke my authorization to use/disclose information indicated in Part 1, between the Person(s)/Organization(s)/Facility(s)/Program(s) whose name and address is:</p> <p>_____</p> <p>_____</p> <p>_____</p>                                                                                                                                                                                                                                                                                                                           |                                    |             |
| <p>I hereby refuse to authorize the use/disclosure indicated in Part 1, between the Person(s)/Organization(s)/Facility(s)/Program(s) whose name and address is:</p> <p>_____</p> <p>_____</p> <p>_____</p>                                                                                                                                                                                                                                                                                                                                        |                                    |             |
| 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 <i>(required if Personal Representative signs Revocation of Authorization)</i>                                                                                                                                                                                                                                                                                                                                                                                          |                                    |             |



Catholic Charities of Cortland County

Provider/Facility Name

About PSYCKES

The New York State (NYS) Office of Mental Health maintains the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES). This online database stores some of your medical history and other information about your health. It can help your health providers deliver the right care when you need it.

The information in PSYCKES comes from your medical records, the NYS Medicaid database and other sources. Go to [www.psyckes.org](http://www.psyckes.org), and click on **About PSYCKES**, to learn more about the program and where your data comes from.

This data includes:

- Your name, date of birth, address and other information that identifies you;
- Your health services paid for by Medicaid;
- Your health care history, such as illnesses or injuries treated, test results and medicines;
- Other information you or your health providers enter into the system, such as a health Safety Plan.

What You Need to Do

Your information is confidential, meaning others need permission to see it. Complete this form now or at any time if you want to give or deny your providers access to your records. What you choose will not affect your right to medical care or health insurance coverage.

Please read the back of this page carefully before checking one of the boxes below. Choose:

- "I GIVE CONSENT" if you want this provider, and their staff involved in your care, to see your PSYCKES information.
- "I DON'T GIVE CONSENT" if you don't want them to see it.

If you don't give consent, there are some times when this provider may be able to see your health information in PSYCKES – or get it from another provider – when state and federal laws and regulations allow it.<sup>1</sup> For example, if Medicaid is concerned about the quality of your health care, your provider may get access to PSYCKES to help them determine if you are getting the right care at the right time.

Your Choice. Please check 1 box only.

- I GIVE CONSENT** for the provider, and their staff involved in my care, to access my health information in connection with my health care services.
- I DON'T GIVE CONSENT** for this provider to access my health information, but I understand they may be able to see it when state and federal laws and regulations allow it.

Print Name of Client

Client's Date of Birth

Client's Medicaid ID Number

Signature of Client or Client's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative Client (if applicable)

<sup>1</sup> Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

- 1 **How providers can use your health information.** They can use it only to:
  - Provide medical treatment, care coordination, and related services.
  - Evaluate and improve the quality of medical care.
  - Notify your treatment providers in an emergency (e.g., you go to an emergency room).
- 2 **What information they can access.** If you give consent, Catholic Charities of Cortland County can see ALL your health information in PSYCKES. This can include information from your health records, such as illnesses or injuries (for example, diabetes or a broken bone), test results (X-rays, blood tests, or screenings), assessment results, and medications. It may include care plans, safety plans, and psychiatric advanced directives you and your treatment provider develop. This information also may relate to sensitive health conditions, including but not limited to:
 

|                                                |                                         |
|------------------------------------------------|-----------------------------------------|
| • Mental health conditions                     | • Genetic (inherited) diseases or tests |
| • Alcohol or drug use                          | • HIV/AIDS                              |
| • Birth control and abortion (family planning) | • Sexually transmitted diseases         |
- 3 **Where the information comes from.** Any of your health services paid for by Medicaid will be part of your record. So are services you received from a state-operated psychiatric center. Some, but not all information from your medical records is stored in PSYCKES, as is data you and your doctor enter. Your online record includes your health information from other NYS databases, and new databases may be added. For the current list of data sources and more information about PSYCKES, go to: [www.psyckes.org](http://www.psyckes.org) and see “About PSYCKES”, or ask your provider to print the list for you.
- 4 **Who can access your information, with your consent.** Catholic Charities of Cortland County's doctors and other staff involved in your care, as well as health care providers who are covering or on call for Catholic Charities of Cortland County. Staff members who perform the duties listed in #1 above also can access your information.
- 5 **Improper access or use of your information.** There are penalties for improper access to or use of your PSYCKES health information. If you ever suspect that someone has seen or accessed your information – and they shouldn't have – call:
  - CCOCC's Compliance Officer at (607) 756-5992, or
  - the NYS Office of Mental Health Customer Relations at **800-597-8481**.
- 6 **Sharing of your information.** Catholic Charities of Cortland County may share your health information with others only when state or federal law and regulations allow it. This is true for health information in electronic or paper form. Some state and federal laws also provide special protections and additional requirements for disclosing sensitive health information, such as HIV/AIDS, and drug and alcohol treatment.<sup>1</sup>
- 7 **Effective period.** This Consent Form is in effect for 3 years after the last date you received services from Catholic Charities of Cortland County, or until the day you withdraw your consent, whichever comes first.
- 8 **Withdrawing your consent.** You can withdraw your consent at any time by signing and submitting a Withdrawal of Consent Form to Catholic Charities of Cortland County. You also can change your consent choices by signing a new Consent Form at any time. You can get these forms at **[www.psyckes.org](http://www.psyckes.org)** or from your provider by calling your CCOCC staff member at (607) 756-5992. Please note, providers who get your health information through Catholic Charities of Cortland County while this Consent Form is in effect may copy or include your information in their medical records. If you withdraw your consent, they don't have to return the information or remove it from their records.
- 9 **Copy of form.** You can receive a copy of this Consent Form after you sign it.

<sup>1</sup> Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as “HIPAA”).