

Authorization to Release Information
to
Columbia County Central Registry
Developmental Disabilities Services Network

Name: _____ **Date of Birth** _____
(Person in Need) (Please print)

Extent or Name of Information to be disclosed: Critical Needs Identification Form: DDP-4
Person in Need or guardian has the right to inspect or copy disclosed information

Purpose or Need for Information: To develop a Central Registry of Service needs for individuals with developmental disabilities. Participating service providers (see attached) will meet on a regular basis to review needs, determine service availability and provide access.

From: _____
Print name and address of agency/program reporting need

To: Taconic DDSO & Columbia County Central Registry/Developmental Disabilities Services Network

I, the undersigned have read the above and authorize discloser of described information. I understand that I can refuse to sign and this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it*. This consent shall expire one (1) year from its signing, unless a different time period, event or condition is specified here. _____ . I also understand that any disclosure is bound by State and Federal Regulations. I understand this authorization is not a condition to receive services.

Notice

Prohibition on Re-disclosure of Information: This information has been disclosed to you from records protected by State and Federal Law. State and Federal Law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains or authorized representative pursuant to said law or as otherwise permitted by law. Any unauthorized further disclosure in violation of State or Federal Law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.

Signature of person in need/legal guardian

Date signed

Signature of witness

Date signed

Printed name of witness

Title of witness

Signature agency/program representative

Date signed

* The cancellation/refusal of this authorization to release information is on the reverse side of this document.

Cancellation/Refusal to Release Information

I hereby cancel my authorization to release information from the Critical Needs Identification Form: DDP-4 to the Taconic DDSO & Columbia County Central Registry/Developmental Disabilities Services Network

I hereby refuse to authorize the release of information from the Critical Needs Identification Form: DDP-4 to the following service providers named below:

Signature of person in need/legal guardian

Date signed

Signature of witness

Date signed

Printed name of witness

Title of witness