



Ontario-Seneca Adult SPOA
609 West Washington St.
Geneva, NY 14456
315-789-0550 FAX: 315-789-0555
Adultspoa@lakeviewhs.org

To whom it may concern:

Thank you for your interest in connecting to services through Ontario and Seneca County's Single Point of Access (SPOA) program. SPOA offers connections to a variety of services that can support members of the community. Below is a brief description of SPOA services:

- **Community Residence (Ontario Only):** (Lakeview Health Services) This rehabilitative program is a homelike setting for individuals seeking daily guidance and support while learning to manage a mental illness. Staff is on site 24 hours. The community residence program is temporary housing, with time-limited lengths of stay.
- **Licensed Apartment Program (Ontario and Seneca):** (Lakeview Health Services) These are smaller, individual apartment settings. Staff are available to assist residents during day and evening hours and are also available by phone during nighttime hours for emergency purposes. Residents work on rehabilitation plans to develop skills to live more independently. The licensed apartment program is temporary housing, with time-limited lengths of stay.
- **Supportive Housing (Ontario and Seneca):** (Lakeview Health Services) This program assists individuals and families in finding and maintaining independent housing in the community. A rent stipend is provided to those who are eligible for the federal Section 8 Rental Assistance program. Staff have contact with individuals on a monthly basis and offers assistance with all housing-related needs. This program is temporary housing, with a primary goal of linkage to Section 8 or long-term housing.
- **Supportive SRO Housing (Ontario Only):** (DePaul Community Services Trolley Station Apartments) This program is a type of affordable housing designed to provide stable and permanent housing for individuals. These SRO units offer private living quarters within a larger building or community, with supportive housing staff who are on site, with office hours Monday through Friday from 8 AM to 5 PM. Services include collaboration with providers and providing necessary linkage toward community integration.
- **Non-Medicaid Care Management (Ontario and Seneca):** (Lakeview Health Services) Services for those without Medicaid, with linkage to surrounding resources in the community, supporting the individual's ability to handle periods of stress that might otherwise overwhelm them. **Medicaid recipients may access Care Management services via HHUNY, rather than through the SPOA process. Please contact the SPOA Coordinator for more info as needed.**
- **Assertive Community Treatment team (ACT) (Ontario and Seneca):** (Elmira Psychiatric Center) An intensive, team-based outpatient mental health service to assist individuals who have not been successful in working with clinics and other traditional forms of treatment. The program is designed

specifically to serve those with serious mental illness and high service needs, such as high use of emergency or crisis services and acute psychiatric hospitals; severe symptomology; coexisting substance abuse disorder; and high risk of justice-system involvement. ACT provides a wide range of support including a 24/7 on-call service, psychiatric care, medication management, counseling for mental health or co-occurring substance use, housing assistance, vocational services, and case management.

Eligibility determination:

- Eligibility requirements are outlined on page three of the SPOA application.
- Eligibility is determined by accessing and reviewing mental health/medical records such as through a web-based database operated by the Office of Mental Health called PSYCKES; and/or by obtaining other mental health/medical records or completing additional screenings as needed on a case-by-case basis.
- Full PSYCKES records are not passed from the SPOA Coordinator to referred service agencies. The SPOA Coordinator will complete an eligibility summary which will document your eligibility determination to share with service agencies.
- The SPOA Coordinator will work with you and/or your referral source on developing a plan to obtain eligibility documentation for services.
- Please review the attached consents providing more information regarding the use of information from Ontario/Seneca County SPOA to determine eligibility.
- In order to determine eligibility, please sign all consents attached to this SPOA application.

If you have any questions, please feel free to reach out.

Thank you

Sincerely,

Ontario/Seneca County SPOA Coordinator

315-789-0550

Email referrals and questions to:

AdultSPOA@lakeviewhs.org

NEW YORK STATE OFFICE OF MENTAL HEALTH CRITERIA FOR SEVERE AND PERSISTENT MENTAL ILLNESS (SPMI) AMONG ADULTS

To be considered an adult diagnosed with severe and persistent mental illness, “1” below must be met, in addition to either “2, “3, or “4.”

1. Designated Mental Illness Diagnosis.

The individual is 18 years of age or older and currently meets the criteria for a *DSM-IV psychiatric diagnosis* other than alcohol or drug disorders (291.xx, 292.xx, 303.xx), organic brain syndromes (290.xx, 293.xx, 294.xx), developmental disabilities (299.xx, 315.xx, 319.xx, or social conditions. ICD-CM categories and codes that do not have an equivalent in DSM-IV are also included mental illness diagnoses.

AND

2. SSI or SSDI Enrollment due to Mental Illness.

The individual is currently enrolled in SSI or SSDI *due to a designated mental illness*.

OR

3. Extended Impairment in Functioning due to Mental Illness.

A. Documentation that 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:

- i. **Marked difficulties in self-care** (personal hygiene; diet; clothing; avoiding injuries; securing health care or complying with medical advice).
- ii. **Marked restriction of activities of daily living** (maintaining a residence; using transportation; day-to-day money management; accessing community services).
- iii. **Marked difficulties in maintaining social functioning** (establishing and maintaining social relationships; interpersonal interactions with primary partner, children, other family members, friends, neighbors; social skills; compliance with social norms; appropriate use of leisure time).
- iv. **Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home, or school settings** (ability 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 repeatedly are unable to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance in the completion of tasks).

OR

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

A documented history shows that the individual at some prior time met the threshold for 3 (above), but the symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. 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.

Adult SPOA Referral Packet

Services requested for (check one):

 Ontario County

 Seneca County

SPOA Received Date: _____ Received By: _____

Programs Requested: *Some are not available in both counties. See p. 1 for descriptions and locations.

 Community Residence (Ont) Licensed Apartment Program Independent Supportive Housing
 Trolley Station SP SRO (Ont) Non-Medicaid Care Mgmt. Finger Lakes/Mid Lakes ACT Team

Client Name: _____ **DOB:** _____

Home Address: _____ **Social Security #:** _____ - _____ - _____
_____ **Age:** _____ **Gender identity:** _____

Telephone Number: _____ **Medicaid CIN** _____

Client's County of Origin: _____ **Email address:** _____

Referral Agency : _____ **Contact Person:** _____

Address: _____

Contact Phone #: _____ **Email:** _____

Person to Notify in Case of Emergency:

What is the client's level of acceptance for this referral?

Name: _____
Address: _____
Telephone: _____
Relationship: _____

- Accepts Interested in pursuing further
- Resistive Does not accept

List the specific needs/reasons for referral: _____

Living Situation at time of referral:

- Lives alone Lives with parents Lives with other relatives Psychiatric Center
- Homeless (street) Lives with spouse Assisted/supported living Correctional Facility
- Homeless (shelter) Supervised living Nursing home/medical setting Other _____

Start date for current living situation: _____

Any adult history of homelessness? Yes No

Does the client need 24-hour supervision? Yes No If yes, why? _____

Previous Residential Program History _____

Current Marital Status:

- Never Married Married Separated Divorced Widowed
- Living with significant other/domestic partner

Custody Status of Children: (check all that apply)

- No children Have children all > 18 yrs old Minor children currently in client's custody
- Minor children not in client's custody but have access Minor children not in client's custody – no access

Ethnicity:

- White (non-Hispanic) Latino/Hispanic Black (non-Hispanic) Native American
- Asian-Asian American Pacific Islander Other or dual (specify):

Current Educational Level:

- Some grade school 1-8th grade Some HS 9-12th grade, no grad GED HS Grad
- Some college, but no degree College Degree
- Vocational, business training No formal education Other: _____

Current Employment Status:

- Employed full-time Employed part-time Not employed Training program Other: _____

Current Criminal Justice Status:

- None Currently incarcerated Release date: _____
 - CPL 330.20 Parole Probation
 - Released from jail/prison in the last 30 days Pending: _____
- Probation/Parole Officer name and phone number: _____

Current or Last Services (check all that apply):

- No prior service MH residential General hospital
- State Psychiatric Center MH outpatient Care management
- Emergency MH

If no current services, specify date of last services: _____

Outpatient Services Current or Planned: (CHECK ALL THAT APPLY)

	Current	Planned		Current	Planned
Psychiatrist/Clinic			Health		
Alcohol/Drug Treatment			Education		
Psychiatric Day Program			Vocational Services		
OMH Housing			AA/NA		
OASAS Housing			Family Support Services		
Care Management			Respite Services		
Child Preventative Services			Adult Care/SNF		
Adult Protective Services			Psychosocial Club		
Representative Payee			Transition Management		

Current CM name/agency _____

Receives ACT: Yes No

Current AOT: Yes No **If yes, please attach copy of AOT orders.**

Mental health service utilization in past 12 months:

Mental Health Clinic (If applicable): _____
Mental Health Provider: _____ Address: _____
Phone Number: _____

Mental Health Diagnoses (Please include ICD 10/DSM 5 Code with each diagnosis listed):

Signs/Symptoms of decompensation (Please be specific):

_____ # Of Psych. ED Visits
_____ # Of Inpatient Psych. Admissions _____ # of days
_____ Admission to Outpatient clinical services (counseling/psychiatry)

Facilities & dates of previous psychiatric treatment and/or hospitalizations:

Behavior/circumstances precipitating most recent hospitalization:

Use/engagement with mental health services:

Does the client understand and accept the need for prescribed medications? Yes No

Rate client compliance with medication regime:
 Independent With Prompting Needs Assistance Resistive

Rate client follow through with Mental Health Appointments:
 Independent With Prompting Needs Assistance Resistive

Cognitive impairment? Yes No Explain: _____

Does the client have a history of any of the following?

			If Yes, Dates
Fire setting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Sexual offense	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Violent acts causing injury or using weapons	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Aggressive /assaultive behavior	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Suicidal ideation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Suicide attempts/gestures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Destruction of property	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Victim of physical abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Victim of sexual abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

If you answered yes to any of the above, please describe the circumstances and method: _____

Are there any guns or weapons in the client's home? Yes No

Medical Health:

Primary Care Physician:

Physician Practice Name (If Applicable): _____
 Name: _____ Address: _____
 Phone Number: _____

(Check all that apply)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Diabetes /metabolic |
| <input type="checkbox"/> BMI over 25 | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Incontinent | <input type="checkbox"/> Impaired ability to walk |
| <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Impaired vision equipment | <input type="checkbox"/> Special medical | <input type="checkbox"/> Other Medical |

Number of medical emergency room visits over the past 12 months: _____

Explanation of medical/emergency issues: _____

Known Allergies:

Medications: _____
 Food: _____
 Other: _____

Are there any specific Emergency Procedures/Protocols to be used by residential staff? What are they?

Substance Use History:

Does the client smoke cigarettes? Yes No If yes, how much/often: _____

Does the client Vape? Yes No If yes, how much/often: _____

Does the client have a history of drug/alcohol abuse/dependency? Yes No

If yes, at what age did use begin? _____ Date of last use: _____

Drugs of Choice: (check all that apply)

- | | | | | |
|--|-----------------------------------|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Methamphetamines | <input type="checkbox"/> Prescription drugs | <input type="checkbox"/> Any IV drug use |
| <input type="checkbox"/> Crack | <input type="checkbox"/> PCP | <input type="checkbox"/> Inhalant: Sniffing glue | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Heroin/Opiates |
| <input type="checkbox"/> Sedative/hypnotic | <input type="checkbox"/> Cannabis | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> Other _____ |

Frequency of Drug Use:

none in past month 1-3 times in past month 1-2 times/week 3-6 times/week daily

Longest period of Sobriety: _____

Chemical Dependency Treatment: Yes No

Substance Use Provider, if applicable, and contact information:

If yes: Services within the past 12 months? Yes No

inpatient programs & dates: _____

outpatient programs & dates: _____

If client is currently in a chemical dependency treatment Program, anticipated discharge date? _____

Previous chemical dependency treatment:

inpatient programs & dates: _____

outpatient programs & dates: _____

Other:

Any other information not covered above, that is relevant to the individual's overall treatment and well-being: (If not, please put N/A)

FUNDING VERIFICATION FORM

	Case #	Currently Receives Y/N	Amount Receives (#)	Pending Application Submitted Y/N	Unknown
Social Security					
SSI					
SSD					
Public Assistance					
Veteran's Benefits					
Medicare					
Medicaid					
Food Stamps					
Pension					
Wages/Earned Income					
Unemployment					
Private Insurance					
Other 3 rd Party Payer					
Trust Fund					
Medication Grant					

Court mandated expenses/debts (i.e., alimony, child support, student loans, utility bills). **Please list all known and amounts:** _____

If Rep Payee, Name: _____ **Address:** _____

Agency: _____ **Telephone #:** _____

PSYCKES CONSENT FORM

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is a web-based application maintained by the New York State (NYS) Office of Mental Health (OMH). It contains health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

PSYCKES data includes identifying information (such as your name and date of birth), information about health services that have been paid for by Medicaid, information about your health care history (such as treatment for illnesses or injuries, test results, lists of medication you have taken), and information entered by you or your treatment provider into the PSYCKES application (such as a Safety Plan).

The health information in PSYCKES can help your provider deliver better care. In this Consent Form, you can choose whether or not to give your provider electronic access to your health information that is in PSYCKES. You can give consent or deny consent, and this form may be filled out now or at a later date. Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent will not be the basis for denial of health services.

If you check the "I GIVE CONSENT" box below, you are saying "Yes, this provider's staff involved in my care may get access to all of my medical information that is in PSYCKES."

If you check the "I DENY CONSENT" box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," THIS DOES NOT MEAN YOUR PROVIDER IS COMPLETELY BARRED FROM ACCESSING YOUR MEDICAL INFORMATION IN ANY WAY. FOR EXAMPLE, IF THE MEDICAID PROGRAM HAS A QUALITY CONCERN ABOUT YOUR HEALTHCARE, THEN UNDER FEDERAL AND STATE REGULATIONS YOUR PROVIDER MAY BE GIVEN ACCESS TO YOUR DATA TO ADDRESS THE QUALITY CONCERN. QUALITY CONCERNS HELP HEALTHCARE PROFESSIONALS DETERMINE WHETHER THE RIGHT SERVICES ARE BEING DELIEVERED AT THE RIGHT TIME TO THE RIGHT PEOPLE. THERE ARE ALSO EXCEPTIONS TO THE CONFIDENTIALITY LAWS THAT MAY PERMIT YOUR PROVIDER TO OBTAIN NECESSARY INFORMATION DIRECTLY FROM ANOTHER PROVIDER FOR TREATMENT PURPOSES UNDER STATE AND FEDERAL LAWS AND REGULATIONS.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices:

I GIVE CONSENT for this provider to access ALL of my electronic health information that is in PSYCKES in connection with providing me any health care services.

I DENY CONSENT for this provider to access my electronic health information that is in PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

Print Name of Patient	Date of Birth of Patient	Patient's Medicaid ID Number
Signature of Patient or Patient's Legal Representative	Date	
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)	
Signature of Witness	Print Name of Witness	

What county does the person reside in (check one)? Ontario Seneca

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, Ontario/Seneca SPOA 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 (Xrays, 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 and see "About PSYCKES", or ask your provider to print the list for you.
4. Who can access your information, with your consent. Ontario/Seneca SPOA's doctors and other staff involved in your care as well as health care providers who are covering or on call for Ontario/Seneca SPOA. 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:
 - Ontario/Seneca SPOA at 3157890550, or the
 - NYS Office of Mental Health Customer Relations at 800-597-8481.
6. Sharing of your information. Ontario/Seneca SPOA 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.
7. Effective period. This Consent Form is in effect for 3 years after the last date you received services from Ontario/Seneca SPOA 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 Ontario Seneca SPOA. 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 or from your provider by calling Ontario Seneca SPOA at 3157890550. Please note, providers who get your health information through Ontario/Seneca SPOA 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.

1 Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27- Page 212 F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

**ONTARIO-SENECA SINGLE POINT OF ACCESS MULTI-AGENCY AUTHORIZATION FORM FOR RELEASE OF
MENTAL HEALTH AND SUBSTANCE ABUSE RECORDS**

Patient information:		
Name:		
Address:		
Birth date:		
AGENCY(S) RECEIVING INFORMATION		
I am referring for services to the following agency(s) and consent to them obtaining clinical documentation. Choose appropriate agency(s):		
<input type="checkbox"/> Lakeview Health Services 609 West Washington Street Geneva NY 14456	<input type="checkbox"/> DePaul-Trolley Station Apartments 2464 County Road 28 Canandaigua NY 14424	<input type="checkbox"/> Elmira Psychiatric Center- Finger Lakes ACT Team 24 A Tillman St Geneva NY 14456

AGENCIES OR PROVIDERS WHO MAY RELEASE INFORMATION			
I have received treatment at the following agencies (please include all agencies where individual has received mental health treatment by checking boxes or writing in 'Other' space below):			
<input type="checkbox"/> Ontario County Mental Health 585-396-4363 (P) 585-396-4993 (F)	<input type="checkbox"/> Clifton Springs/ Canandaigua Behavioral Health 315-462-1050 (P) 315-462-0145 (F)	<input type="checkbox"/> UR Medicine Behavioral Health 585-273-5050 (P) 585-546-2799 (F)	<input type="checkbox"/> Seneca County Community Counseling 315-539-1980 (P) 315-539-1054 (F)
<input type="checkbox"/> Seneca Ontario Community Services 315-568-9412 (P) 315-568-6718 (F)	<input type="checkbox"/> Wayne Behavioral Health 315-946-5722 (P) 315-946-5726 (F)	<input type="checkbox"/> FLACRA 585-396-4190 (P)	<input type="checkbox"/> Canandaigua Lake Counseling 585-919-0014 (P) 585-393-0014 (F)
Other Agencies or Providers:			

INFORMATION TO BE RELEASED:	
I hereby consent and permit the above agencies and program(s) I have designated under the Ontario/Seneca Single Point of Access program, to disclose, communicate and discuss with each other, the following information, as indicated by my initials on each designated line:	
<u>Mental Health Treatment</u>	_____ my name and other personal identifying information; my status as a patient in mental health treatment, most recent evaluation of my service needs for mental health treatment, most recent service plan, and/or discharge plan(s) for mental health treatment, dates of and discharge status
<u>Substance Abuse Treatment (if any)</u>	_____ my name and other personal identifying information; my status as a patient in alcohol/substance abuse treatment, including dates of treatment and attendance; initial and subsequent evaluations of my service needs for alcohol/substance abuse treatment; summaries of alcohol/substance abuse assessment(s) or evaluation(s) results and history, service plans.

ONTARIO-SENECA SINGLE POINT OF ACCESS MULTI-AGENCY AUTHORIZATION FORM FOR RELEASE OF MENTAL HEALTH AND SUBSTANCE ABUSE RECORDS

PURPOSE OF DISCLOSURE

This information is being requested to permit the agency(s) designated to receive information necessary to complete my intake for services and supports referred through Ontario/Seneca Single Point of Access.

NOTICES

I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:

- Only the information described in this form may be used and/or disclosed as a result of this authorization
- This information is confidential and protected by HIPAA (45 CFR Parts 160 and 164) federal privacy protections and the NYS Mental Hygiene Law.
- 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 and NYS Mental Hygiene Law §33.16.
- All parties cannot further disclose any information obtained through the use of this authorization without my written permission, unless otherwise permitted by this release.
- Confidentiality of alcohol or substance abuse treatment records are protected under HIPAA (45 CFR Parts 160 and 164) and federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2).
- Alcohol and substance abuse treatment records cannot be disclosed without my written consent unless otherwise permitted in the above regulations.
- I understand that generally the substance abuse program may not condition my treatment on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Revocation

- I may revoke this consent at any time, in writing. The written revocation must be provided to Ontario/Seneca SPOA Coordinator and/or representative of the program in which I am referred to.
- I am aware my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already disclosed the records based upon my prior consent.

Duration/Expiration

- Unless previously revoked, this authorization permits the disclosure of my mental health and/or substance abuse treatment records to the agency I have designated for a duration of 1 year.

(Signature of Patient)

(Signature of Guardian, if necessary)

Print name of Patient

Print name of Guardian, if necessary

Date

Date