Consumer Name: _____

APPLICATION
ULSTER COUNTY SINGLE POINT OF ACCESS (SPOA)
FOR ADULT RESIDENTIAL SERVICES

HOW TO APPLY?

The SPOA for Adult Residential Services is a centralized intake system to manage, and triage housing referrals to all available Office of Mental Health (OMH) vacancies. Attached is an application for your use in submitting referrals. For a referral to be considered, the following documentation must be included:

1. A DSM-5 diagnosis that meets criteria for Serious Mental Illness (SMI)
2. A DSM-5 diagnosis with an extended impairment of functioning due to mental illness
3. Adult SPOA Application for Residential Services
4. **A psychiatric evaluation completed within the last 12 months**
5. Three (3) consents to release information (see SPOA application)
6. A level of housing form (see SPOA application page 2) with the level requested checked off ***A CONSUMER WHO IS CURRENTLY RECEIVING SECTION 8 ASSISTANCE IS NOT ELIGIBLE FOR SUPPORTED HOUSING**
7. Identify source of income
8. PHYSICIAN'S AUTHORIZATION FOR RESTORATIVE SERVICES (**Must be filled out by a licensed MD only**. A Nurse Practitioner is **NOT** acceptable)
9. The following information is optional, but helpful and can be submitted to the Adult SPOA Coordinator after the initial application is received:
   - a psycho-social assessment
   - a psychological evaluation
   - a current comprehensive treatment plan
   - recent medication notes
   - any other specialized tests/evaluations/consultations as deemed appropriate
10. Submit the application and supporting documentation via mail, fax or email (scan) to:

Adult SPOA Coordinator
Ulster County Department of Mental Health
239 Golden Hill Lane
Kingston, New York 12401
845-340-4110
Fax: 845-340-4094
mshl@co.ulster.ny.us

SPOA PROCESS AND ADMISSION REQUIREMENTS:

1. Once the application/referral packet is received, it will be presented to the SPOA Adult Residential Services Committee. The Committee is comprised of the various providers of residential services in Ulster County. The Committee determines whether the client/consumer meets the criteria and is deemed appropriate.

2. Prior to admission, a trial visit will be arranged for the client/consumer. In order for a trial visit to occur, the following must be in place:

   - FUNDING (SSI/SSD/DSS/MEDICAID, etc.)
   - OUTPATIENT MENTAL HEALTH TREATMENT SERVICES

3. Upon Admission to a residential service the following documentation is required:

   - MEDICAL/PHYSICAL EXAMINATION WITH RESULTS OF A PPD TEST (Done within the last 12 months).

Consumer Name: _____

LEVEL OF HOUSING

Check appropriate box to where referral is to be made:

GATEWAY COMMUNITY INDUSTRIES (GCI)

LEVEL I Community Residence

☐Gateway Manor (New Paltz) ***24 Hour Supervision***

LEVEL II Supportive Apartments

☐Scattered Site Supportive Apartments (Kingston) ***1-3 Visits per Week***

☐The Newkirk Project (Dual Diagnosis) (MH/OPWDD) ***21-24 Hour Supervision***

☐Ulster Gardens Apartments (Kingston) ***1-3 Visits per Week***

LEVEL III Supported Housing

☐Gateway Apartments (Kingston, Scattered) ***Regular Visits as Needed***

☐Gateway Family Apartment (HUD Homeless only) ***Regular Visits as Needed***

☐Ulster Gardens Apartments (Kingston) ***Regular Visits as Needed***

REHABILITATION SUPPORT SERVICES, INC. (RSS)

LEVEL I Community Residence

☐Highridge Gardens (Poughkeepsie) ***24 Hour Supervision***

LEVEL II Supportive Apartments

☐Kingston ***1-3 Visits per Week***

LEVEL III Supported Housing

☐Ulster County ***Regular Visits as Needed***

MENTAL HEALTH ASSOCIATION (MHA)

LEVEL II Supportive Apartments

☐Training Apartment Program (TAP) (Lake Katrine, NY) ***24 Hour Supervision***

☐Locust Street Certified Apartment Program (Kingston, NY) ***Supervised 8am- 10pm***

☐Scattered Site ***1-3 Visits per Week***

LEVEL III Supported Housing

☐Kingston Area Units ***Regular Visits as Needed***

PEOPLe, Inc

LEVEL III Supported Housing

☐Ulster County ***Regular Visits as Needed***

Consumer Name: _____

RESIDENTIAL SERVICES APPLICATION

Level of Care Being Requested: _____

REFERRAL SOURCE DATA			
Date of Referral:	**Referred By:**	**Title:**	
Agency:		**Phone #: _____ Extension: _____** **E-mail address _____**	
Mailing Address:	**City**	**State**	**Zip Code**

CONSUMER DATA				
Name: Last First Middle				**Current Address:**
Age:	**Date of Birth:**	**Current Telephone #:** **Cell:** **Home:**		**City/State/Zip:**
County of Residence:		**Length of Residence:**		**Is Consumer on:** **Probation:** ☐Yes ☐No **Parole:** ☐Yes ☐No **Name of P.O.:** _____
Gender: ☐**Male** ☐**Female**	**Marital Status:** ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed**			

List last three previous addresses chronologically:

1. _____

2. _____

3. _____

Number of Children: _____ **Ages: _____**	**Religion (if declared):**	**Veteran:** ☐**Yes** ☐**No** ☐**Unknown**

Education (Highest completed): ☐GR ☐HS ☐College ☐Graduate	**Read:** ☐Yes ☐No **Write:** ☐Yes ☐No Primary Language:	**Employment Status:**

Homeless:
☐**Yes** ☐**No**

If yes, where is the consumer staying now:

Wrap Plan? ☐**Yes** ☐**No**	**Advanced Directives?** ☐**Yes** ☐**No**	

Consumer Name: _____

ASSISTED OUTPATIENT TREATMENT (AOT)				
Check any that apply: ☐**AOT Enhanced** ☐**AOT Petition** ☐**High Risk**				
CONSUMER DSM-5 DIAGNOSIS (as stated on Psychiatric Evaluation)	**ICD-10 Codes**			
1.	**F**		**.**	
2.	**F**		**.**	
3.	**F**		**.**	
4.	**F**		**.**	
5.	**F**		**.**	
6.	**F**		**.**	

DEVELOPMENTAL DISABILITIES DIAGNOSIS ONLY (OPWDD):	
Diagnosis: ☐**Intellectual Developmental Disorder** ☐**Autism** ☐**Cerebral Palsy** ☐**Asperger Syndrome** ☐**Fetal Alcohol Syndrome** ☐**Down Syndrome**	
Full Scale IQ:	**Disability Manifested Prior to Age 18?** ☐**Yes** ☐**No**
Does this consumer have OPWDD eligibility and /or WAIVER status? ☐**Yes** ☐**No**	

SERVICE PROVIDER INFORMATION:			
Provider	**Name**	**Agency**	**Phone #**
Primary Therapist:			
Prescribing Physician/Psychiatrist:			
Probation/Parole Department *If applicable:*			
Care Management:			
Current Treatment Program:			

Consumer Name: _____

FINANCIAL INFORMATION			
SSN:	**Medicaid #:** ☐**Active** ☐**Not Active**	**Medicare #:**	**Temporary Assistance/Welfare Amount:**

Employment Earnings (Monthly)	**SSI:** ☐Yes ☐No **SSI Amount: $_____**	**SSDI:** ☐**Yes** ☐**No** **SSDI Amount: $_____** **Spend down:** ☐**Yes** ☐**No**	**Does Consumer Have Bank Account?** ☐Yes ☐No
Other Benefits or Income?		**Other Insurance: (Health, Life, Auto): List below:**	

Current Payee ☐Yes ☐No ☐Pending ☐Payee Recommended	**Current Payee's Name:**	**Relationship:**	**Phone #:**
Payee's Address:	**City:**	**State:**	**Zip:**

FAMILY AND SIGNIFICANT RELATIONSHIP INFORMATION	
Next of Kin/Legal Guardian/Significant Other:	**Address:**
Relationship:	**Phone:**

Is family involved with consumer: ☐**Yes** ☐**No**

Describe quality of relationships (include emotional and health factors of family when applicable)

_____

REASON FOR REFERRAL TO THIS LEVEL OF CARE

Briefly explain (excluding symptoms) why the consumer is in <u>need</u> of this level of care. Include how much supervision consumer needs:

MEDICAL INFORMATION

Physical Problems/Disabilities/Restriction: ☐**Yes** ☐**No**

If yes, explain

_____

Allergies: ☐**Yes** ☐**No**

If yes, list and/or explain

_____

Does Consumer Have a History of Seizure Disorder? ☐**Yes** ☐**No**

If yes, explain

_____

Consumer Name: _____

ALCOHOL AND SUBSTANCE USE/ABUSE (Last Five Years)		
Does Consumer Have a History of Alcohol/Substance Abuse? ☐**Yes** ☐**No** ***If yes, list substance(s), date of last use, treatment history.***		
Substance	**Date of Last Use**	**Treatment History**

PREVIOUS PSYCHIATRIC HOSPITALIZATIONS (Last Five Years)			
Hospital	**Reason for Admission**	**Admit Date**	**Discharge Date**

MEDICATIONS
Is the Consumer able to self-administer medications? ☐Yes ☐No
Does Consumer Have History of Medication Non-compliance? ☐**Yes** ☐**No** **If Yes, Explain:** _____

RISK FACTORS		
Arson: ☐Yes ☐No	***Date or Age:***	***Explain:***
Suicide Attempts: ☐Yes ☐No		
Suicide Gestures: ☐Yes ☐No		
Criminal Offenses: ☐Yes ☐No		
Assaultive Behavior: ☐Yes ☐No		
Drug/Alcohol Abuse: ☐Yes ☐No		
Danger to Others: ☐Yes ☐No		
Danger to Property: ☐Yes ☐No		

Consumer Name: _____

AUTHORIZATION FOR RESTORATIVE SERVICES OF COMMUNITY RESIDENCES

☐Initial Authorization
☐Semi-Annual Authorization
☐Annual Authorization

CONSUMER'S NAME:	
CONSUMER'S MEDICAID NUMBER:	
ICD-10 DIAGNOSIS CODE:	
DATE LAST SEEN:	

I, the undersigned **licensed physician**, based on my review of the assessments made available to me, have determined that _____ would benefit for the provision of mental health restorative services defined pursuant to Part 595 of the 14 NYCRR.

(Consumer's Name)

This determination is in effect for the period _____to_____,

(Start Date) (End Date)

At which time there will be an evaluation for continued stay.

_____/_____/_____ _____ _____

Mo. Day Year Name (Please Print) License #

_____

Signature

☐Check here if consumer is enrolled in Managed Care (e.g., an HMO or Managed Care Coordinator Program) and enter Primary Care Physician and Managed Care Provider Identification Number.

_____ _____

Physician Managed Care Provider ID#

SPOA RESIDENTIAL CONSENT: PART 1

Consumer's Name: DOB:

This authorization must be completed by the consumer or his/her personal representative to use/disclose protected health information, in accordance with State and Federal Laws and Regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the consumer or another person. A separate authorization is required to use or disclose confidential HIV related information.

AUTHORIZATION TO RELEASE INFORMATION TO THE SPOA COMMITTEE

Description of Information to be Used/Disclosed: Mental Health Treatment history; Mental Health Diagnosis; Psychiatric Evaluation; Psychosocial Evaluation; Psychological Testing (if applicable); Physical Exam and PPD.

Other: _____

Purpose or Need for Information:

1. This information is being requested:

☐ By the consumer or his/her personal representative for release to a person or entity with a demonstrable need for the information; or

☒ Other (please describe) **RESIDENTIAL SPOA COMMITTEE**

2. The purpose of the disclosure is (please describe**): to exchange information about the SPOA consumer, with the agencies or persons listed below, in order to link the consumer with requested residential service or program.**

Information Being Disclosed From: (Name, Address of Organization/Facility/Program)

Information Being Disclosed To: (*Note: All referrals, including the information indicated above, are forwarded to the SPOA Coordinator who then disseminates them to any of the Residential Service Providers listed below)*

- Mental Health Association in Ulster County, Inc.
- Gateway Community Industries, Inc.
- PEOPLe, Inc.
- Rural Ulster Preservation Company
- Health Alliance of the Hudson Valley – Inpatient Unit
- Chiz's Heart Street
- Rehabilitation Support Services, Inc.
- Access Supports for Living: Mobile Mental Health
- Ulster-Greene ARC
- Other_____

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 the information described in this form may be used and/or disclosed as a result of this authorization.
2. This information is confidential and is protected under federal privacy regulations (HIPAA) and the NYS Mental Hygiene Law and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be redisclosed and would no longer be protected by HIPAA. However, this information will still be protected under the NYS Mental Hygiene Law, which prohibits this information from being redisclosed by anyone who receives it unless the redisclosure is permitted by the NYS law (Mental Hygiene Law §33.13).
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 *(insert name of facility/program)* **UCDMH SPOA**.
   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 and NYS Mental Hygiene Law §33.16).

Consumer Signature: I certify that I authorize the use of my health information as set forth in this document.

_____ _____

Signature of Consumer or Personal Representative Date

_____

Consumer's Name (Printed)

_____

Personal Representative's Name (Printed)

Description of Personal Representative's Authority to Act for the Consumer *(required if Personal Representative signs Authorization)*

REVOCATION OF AUTHORIZATION TO RELEASE/OBTAIN INFORMATION: I hereby revoke my authorization to release/obtain information, indicated in Part 1, to the person/organization/facility/program listed below:

Signature: Date:

SPOA RESIDENTIAL CONSENT: PART 2

AUTHORIZATION FOR THE EXCHANGE OF INFORMATION
BETWEEN ULSTER COUNTY DEPARTMENT OF MENTAL HEALTH SPOA COMMITTEE AND OTHER SERVICE PROVIDERS

Name: _____ DOB: _____

This authorization must be completed by the consumer or his/her personal representative to use/disclose protected health information, in accordance with State and Federal Laws and Regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the consumer or another person. A separate authorization is required to use or disclose confidential HIV related information.

PURPOSE OF NEED FOR INFORMATION:
The UCDMH SPOA Coordinator requires your permission to release and obtain your confidential information in order to pursue your request for residential services. The information to be released/obtained includes: the SPOA application, income verification, psychiatric evaluation /update, psychosocial assessment (including diagnosis, mental status), psychological testing, discharge summary, physical/medical specialist exams, PPD results (chest X-ray if needed).

I hereby authorize the Ulster County Department of Mental Health SPOA Coordinator to exchange information with the following agencies as part of the SPOA Process:

☐ Access: Supports for Living, Inc./Clinic Treatment
☐ Access: Supports for Living, Inc./Mobile Mental Health Team
☐ ACT Team (MHA in Ulster County, Inc.)
☐ Always There Home Care
☐ Bob Hasbrouck's
☐ Bon Secours Hospital
☐ The Bridge Back
☐ Children's Home-Poughkeepsie/Kingston
☐ Chiz's Heart Street
☐ CREATE/PROS
☐ Department of Social Services-Ulster/Dutchess
☐ Family Care/OMH
☐ Family of Woodstock, Inc.
☐ Four Winds Hospital
☐ Gateway Community Industries, Inc.
☐ HAHV/Broadway Campus
☐ HAHV/Emergency Department
☐ HAHV/Mary's Avenue Campus/Inpatient
☐ HAHV/Partial Hospitalization-Adult/Adolescent
☐ Hudson Valley Community Services
☐ Hudson Valley Mental Health, Inc.
☐ The Institute for Family Health
☐ Mental Health Association- Ulster/Dutchess
☐ Mid-Hudson Regional Hospital of Westchester
☐ New York Presbyterian
☐ New York State Department of Community Corrections Services
☐ Parole (New York State)
☐ Parson's Child and Family Center
☐ PEOPLe, Inc
☐ Phelps Hospital
☐ Pine Grove Center
☐ Probation (Ulster County)
☐ Putnam Hospital
☐ RCAL
☐ Rehabilitation Support Services, Inc.
☐ Rockland's Children's Psychiatric Center
☐ Rockland's Psychiatric Center
☐ RUPCO
☐ Spectrum Behavioral Health
☐ Step One
☐ UGARC
☐ Ulster County Department of Mental Health
☐ Ulster County Jail
☐ Willcare Home Health
☐ Other _____
_____
_____
☐ Emergency Contact
_____

SPOA RESIDENTIAL CONSENT: PART 2

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 the information described in this form may be used and/or disclosed as a result of this authorization.
2. This information is confidential and is protected under Federal Privacy Regulations (HIPAA) and the NYS Mental Hygiene Law and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be redisclosed and would no longer be protected by HIPAA. However, this information will still be protected under the NYS Mental Hygiene Law, which prohibits this information from being redisclosed by anyone who receives it unless the redisclosure is permitted by the NYS Law (Mental Hygiene Law §33.13).
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 *(insert name of facility/program)* **UCDMH SPOA**.
   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 and NYS Mental Hygiene Law §33.16).

PERIODIC USE/DISCLOSURE: I hereby authorize the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as often as necessary to fulfill the purpose identified above. My authorization will expire:

☐ when I am no longer receiving SPOA residential services

☐ other_____

CONSUMER SIGNATURE: I certify that I authorize the use of my health information as set forth in this document

Signature of Consumer or Personal Representative _____ Date:_____

Consumer's Name (Printed) : _____ Personal Representative's Name (Printed): _____

Description of Personal Representative's authority to act for the Consumer (required if Personal Representative signs authorization): _____

_____

REVOCATION OF AUTHORIZATION TO RELEASE/OBTAIN INFORMATION: I hereby revoke my authorization to release/obtain information, indicated in Part 2, to the person/ organization/facility/program listed below:

_____

_____

SIGNATURE:_____ DATE: _____

SPOA PACKET

PSYCKES Consent Form

This PSYCKES consent form allows your provider/referent to obtain Medicaid information through PSYCKES, an electronic database. This database contains all the different types of health services you have received through Medicaid. Once you consent, those providers/referents will have access to indicators which will enable them to help you in treatment planning and help coordinate all the different types of health services you have received through Medicaid. Your choice to consent or deny will not affect your ability to get medical care or health insurance coverage. Understand that your provider may be able to obtain your information even without your consent for certain limited purposes if specifically authorized by the state and federal laws and regulations.

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

☐ **I give consent** for the SPOA participants to access all of my electronic health information through PSYCKES in connection with providing me any health care services. YOU ARE ABLE TO WITHDRAW THIS CONSENT AT ANY TIME DURING THE SPOA PROCESS. SEE ATTACHED WITHDRAWAL FORM.

☐ **I deny consent** for the SPOA participants to access my electronic health information through PSYCKES.

The following are SPOA participants: Ulster County Department of Mental Health; Department of Social Services-Adult; Mental Health Association and ACT; Gateway Community Industries; Rockland Psychiatric Center (Pine Grove Center); Hudson Valley Health Alliance-Inpatient; Hudson Valley Health Alliance Partial Programs; Family of Woodstock; Willcare Home Care; UC Probation; PEOPLe, Inc.; Institute of Family Health; Rehabilitation Support Services , Inc.; Hudson Valley Mental Health

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

Information About the PSYCKES Consent for Your Records

Details about patient information in PSYCKES and the consent process:

1. **How Your Information Will be Used.** Your electronic health information will be used by only to:
    - Provide you with medical treatment and related services
    - Evaluate and improve the quality of medical care provided to all patients

Note: The choice you make in this Consent form does *not* allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information About You are Included?** If you give consent , Ulster Co. SPOA Agencies may access all of your electronic health information available through PSYCKES. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to :
    - Mental health conditions
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or test
    - HIV/AIDS
    - Sexually transmitted diseases
3. **Where Health Information About You Comes From.** Information about you in PSYCKES comes from the New York State Medicaid Program.
4. **Who May Access Information about You, if you Give Consent.** Only these people may access information about you; doctors and other health care providers who serve on the Ulster Co. SPOA Agency's medical staff who are involved in your medical care; health care providers who are covering or on call for the SPOA Agency's doctors; and staff members who carry out activities permitted by this Consent Form as described in paragraph one.
5. **Penalties for Improper Access to or Use of your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Ulster co LGC at 340-4110; or call the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health inform, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information.
7. **EFFECTIVE PERIOD.** This consent Form will remain in effect until three (3) years after the last date you received any medical services, 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 a Withdrawal of Consent Form and giving it to the Ulster Co. SPOA Coordinator at USDMH, 239 Golden Hill Lane, Kingston, NY 112401 or phone her at 845-349-4193. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms form this provider or from the PSYCKES website at www.psyckes.com or by calling Ulster Co. Department of Mental Health at 340-4110. Note: Organizations that access your health information through SPOA Agencies that serve you while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw you consent, they are not required to return it or remove it from their records.

Copy of Form: You are entitled to receive a copy of this Consent Form after you sign it.

PSYCKES Withdrawal of Consent Form

You previously signed a PSYCKES Consent form allowing your provider to obtain access to your Medicaid medical records electronically through PSYCKES and now want to withdraw that consent. This form may be filled out now or at a later date.

By withdrawing Consent, you understand that:

1. Health care providers and health insurers that you are enrolled with will no longer be able to access Medical Information about you through PSYCKES, except in an emergency or if another exception to the State and federal confidentiality laws and regulations applies. 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.

2. Your provider is not completely barred from accessing your medical information in any way. It may still be able to obtain necessary information directly from another provider for treatment purposes under state and federal laws and regulations.

3. The Withdrawal of Consent will not affect the exchange of your Medical Information made while your Consent was in effect.

4. No PSYCKES participating provider will deny you medical care and your insurance eligibility will not be affected based on your Withdrawal of Consent.

5. If you wish to reinstate Consent, you may do so by signing and completing a new PSYCKES Consent form and returning it to a participating provider.

6. Withdrawing your consent does not prevent your health care providers from submitting claims to your health insurer for reimbursement for services rendered to you.

7. You understand that you will get a copy of this form after you sign it.

Print Name of Patient:	Date of Birth of Patient:
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: