Cayuga
MEDICAL CENTER
A Member of Cayuga Health System
101 Dates Drive
Ithaca, NY 14850
(607)274-4011

A00082793308
BLAYK,BONZE ANNE ROSE
Clifford Ehmke MD
F 60
DOB 05/01/1956

Consent To Release Medical Information to Designated Caregiver

I hereby designate the individual listed below as my primary caregiver in accordance with Article 29-CCCC of the Public Health Law (the CARE Act). I consent to Cayuga Medical Center to disclosing medical information regarding my care and treatment to my designated caregiver for purposes of discharge planning and post-discharge care information and instruction. I may change my designated caregiver at any time by notifying a member of my treatment team.

I understand that designating a caregiver and consenting to the disclosure of medical information to my caregiver is voluntary and that I can revoke the designation or consent to share information with my designated caregiver at any time by notifying a member of my treatment team.

Designated Caregiver Information	
Caregiver Name	Caregiver Phone #
Relationship to Patient ☐ Spouse ☐ Significant Other ☐ Sibling ☐ Parent ☐ Legal Guardian ☐ Neighbor ☐ Friend ☐ Other (specify) ☐ Child _____	Caregiver Address

_____ _____
Patient or Legal Guardian Signature **Date/Time**

Pt. declined. 2-10-17 1105 Sa. N

Caregiver Designation Change
I hereby elect to remove the caregiver listed below and I understand that I may designate a new caregiver by filling out a separate consent. **Name of caregiver being removed** _____

_____ _____
Patient or Legal Guardian Signature **Date/Time**

(17130)

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
BLAYK, BONZE ANNE ROSE A00082793308 M000597460 Patient Address 05/01/1956 60 F Ehmke, Clifford BSU 202-01		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

Tompkins County Mental Health Clinic, 201 E. Green St., Ithaca, NY 14850 (ph:607-274-6200; f:607-274-6224)

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

Cayuga Medical Center, 101 Dates Drive, Ithaca, NY 14850 (ph:607-274-4304; f:607-274-4130)

7. Purpose for Release of Information:

Information sharing between parties to coordinate treatment and discharge planning.

8. Unless previously revoked by me, the specific information below may be disclosed from: 02/09/17 (INSERT START DATE) until 02/09/18 (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☑ Clinical records from mental health programs*	Summary of outpatient treatment, initial assessment, progress notes, lab work, medications, treatment plan, and treatment status/updates.	X BARB
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

X Bonze Blayk — SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW — DATE 02/09/17

Witness Statement/Signature: 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 authorized representative.

Alison Bliss LMSW — STAFF PERSON'S NAME AND TITLE — SIGNATURE — DATE 02/09/17

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records 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 patient or another person.

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	BLAYK, BONZE ANNE ROSE A00082793308 M000597460 05/01/1956 60 F
Patient Address	Ehmke, Clifford BSU 202-01

Date of Birth	Patient Identification Number

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

Cayuga Medical Center, 101 Dates Drive, Ithaca, NY 14850 (ph:607-274-4304; f:607-274-4130)

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

Tompkins County Mental Health Clinic, 201 E. Green St., Ithaca, NY 14850 (ph:607-274-6200; f:607-274-6224)

7. Purpose for Release of Information:

Information sharing between parties to coordinate treatment and discharge planning.

8. Unless previously revoked by me, the specific information below may be disclosed from: 02/09/17 (INSERT START DATE) until 02/09/18 (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☑ Clinical records from mental health programs*	Mental health evaluation, History & Physical, psychosocial, progress notes, lab work and status of inpatient treatment.	X BARB
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

Bonze Blayk — SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW — 02/09/17 DATE

Witness Statement/Signature: 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 authorized representative.

Alison Bliss, LMSW — STAFF PERSON'S NAME AND TITLE — Alison Bliss — SIGNATURE — 02/09/17 DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records 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 patient or another person.

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Pati

BLAYK, BONZE ANNE ROSE
A00082793308 M000597460
05/01/1956 60 F
Ehmke, Clifford BSU 202-01

	Date of Birth	Patient Identification Number

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

Cayuga Medical Center, 101 Dates Drive, Ithaca, NY 14850 (ph:607-274-4304; f:607-274-4130)

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

Nick Berg - Tompkins County Mental Health - 201 E. Green St, Ithaca, NY 14850

7. Purpose for Release of Information:

Information sharing between parties to coordinate treatment and discharge planning.

Unless previously revoked by me, the specific information below may be disclosed from: 2/1/17 (INSERT START DATE) until 6/1/17 (INSERT EXPIRATION DATE OR EVENT)

☑ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☑ Records from alcohol/drug treatment programs	ALL from ~~[illegible]~~ date 12/1/16	BARB
☑ Clinical records from mental health programs*	Summary of treatment, initial assessment, progress notes, treatment plan, treatment status/updates, and discharge plan.	X BARB
☑ HIV/AIDS-related Information	ALL from date 12/1/16	

9. ~~If not the patient~~, name of person signing form: Bonze Anne Rose Blayk - patient

10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

Bonze Blayk — 2/1/17
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW — DATE

Witness Statement/Signature: 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 authorized representative.

[illegible] MHT - Matthew Young — 2/1/17
STAFF PERSON'S NAME AND TITLE — SIGNATURE — DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records 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 patient or another person.

DOH-5032 (4/11)

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Pa BLAYK, BONZE ANNE ROSE
A00082793308 M000597460
Pa 05/01/1956 60 F
Ehmke, Clifford BSU 202-01

	Date of Birth	Patient Identification Number

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:
Nick Berg - Tompkins County Mental Health - 201 E. Green St., Ithaca NY 14850

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:
Cayuga Medical Center, 101 Dates Drive, Ithaca, NY 14850

7. Purpose for Release of Information:
Information sharing between parties

8. Unless previously revoked by me, the specific information below may be disclosed from: 2/1/17 (INSERT START DATE) until 8/1/17 (INSERT EXPIRATION DATE OR EVENT)

☑ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☑ Records from alcohol/drug treatment programs	All from start date	BARB
☑ Clinical records from mental health programs*	All from start date	BARB
☑ HIV/AIDS-related Information	All from start date	BARB

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

Bonze Blayk — 2/1/17
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW — DATE

Witness Statement/Signature: 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 authorized representative.

STAFF PERSON'S NAME AND TITLE — MHT Matthew Young S — SIGNATURE — DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records 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 patient or another person.

NEW [redacted] DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Pa BLAYK, BONZE ANNE ROSE
A00082793308 M000597460
05/01/1956 60 F
Pr Ehmke, Clifford BSU 202-01

	Date of Birth	Patient Identification Number

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

Cayuga Medical Center, 101 Dates Drive, Ithaca, NY 14850 (ph:607-274-4304; f:607-274-4130)

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

Nick Berg

7. Purpose for Release of Information:

Information sharing between parties to coordinate treatment and discharge planning.

8. Unless previously revoked by me, the specific information below may be disclosed from: 1/23/17 (INSERT START DATE) until 2/28/17 (INSERT EXPIRATION DATE OR EVENT) BARB

☑ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☑ Clinical records from mental health programs*	ALL	BARB
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

Bonze Blayk — SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW — 1/23/17 DATE

Witness Statement/Signature: 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 authorized representative.

STAFF PERSON'S NAME AND TITLE — SIGNATURE — DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records 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 patient or another person.

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patie BLAYK, BONZE ANNE ROSE
A00082793308 M000597460
Patie 05/01/1956 60 F
Ehmke, Clifford BSU 202-01

	Date of Birth	Patient Identification Number

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:
Nick Berg

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:
Cayuga Medical Center, 101 Dates Drive, Ithaca, NY 14850 (ph:607-274-4304; f:607-274-4130)

7. Purpose for Release of Information:
Information sharing between parties to coordinate treatment and discharge planning.

8. Unless previously revoked by me, the specific information below may be disclosed from: 1/23/17 (INSERT START DATE) until 2/28/17 (INSERT EXPIRATION DATE OR EVENT)

☑ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☑ Clinical records from mental health programs*	ALL	BARB
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

Bonze Ehmke — 1/23/17
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW — DATE

Witness Statement/Signature: 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 authorized representative.

STAFF PERSON'S NAME AND TITLE — SIGNATURE — DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records 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 patient or another person.