THE SINGLE POINT OF ACCESS (SPOA)
AUTHORIZATION OF RELEASE AND RE-RELEASE OF INFORMATION

The NYC Department of Health and Mental Hygiene (DOHMH) serves as the Single Point of Access (SPOA) for New York City. SPOA staff assess eligibility for services and make referrals to a variety of mental health services, including Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Intensive Mobile Treatment (IMT), Shelter ACT, and Care Coordination. By signing this authorization form, you are consenting to: 1) the release of the SPOA application and all supporting documents to SPOA for the purposes of determining whether you are eligible for services; 2) the release of your health information or your other confidential information held by the entity listed below to SPOA for the purposes of determining whether you qualify for services; and 3) the re-release of your information by SPOA to the mental health agency you are assigned to if you are found eligible for services. This authorization will expire 120 days from the date it is received. SPOA will not re-release any of your HIV/AIDS-related information that it may receive unless we receive your express written permission.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment nor will it affect my eligibility for services. I further understand that the agency I am assigned to may require a signed consent form in order to provide services to me. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and this redisclosure may no longer by protected by federal or state law.

I have the right to revoke this authorization at any time by writing to the provider listed below and/or to DOHMH, ATTN: SPOA, 42-09 28th St., Long Island City, NY 11101. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my information have already taken action because of my earlier authorization.

1. Patient Name	2. Date of Birth
3. Patient Address	
4. Name and address of health provider or entity to release this information:	
5. Specific information to be released: ☐ Medical record from (insert date) _____ to (insert date)_____ ☐ Other: _____ _____	
6. If not the patient, the name of the person signing the form:	7. Authority to sign on behalf of the 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.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW **DATE**

Witness Statement/Signature: I have witnessed 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**