



Part I. Name and Address of Individual

Form with fields for Last, First, MI, Last 4 digits of Social Security Number, Address, Date of Birth, and Phone Number.

Part II. Authorization for Use and Disclosure of Information, Including Protected Clinical Information:

Authorizes OPWDD to use or disclose the following information about you: Describe the information to be used or disclosed (check all that apply):

Dates of service (if applicable):

Images of me, My name, My residence or program attended, Other, please describe:

For the publication purposes described below: Describe the purposes for use or disclosure (check all that apply):

Select all Posting on the OPWDD Internet Website, Printed Publications, Release to Media, Training materials, Video recordings, Other, please describe:

Note: the following must be completed by health care providers or health plans requesting the authorization:

Will the health care provider or health plan requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health or clinical information described above?

No Yes

1) I understand that I will not receive any payment or compensation for the use or disclosure of any photographs or likenesses of me or the use or disclosure of any other information about me for the publication purposes I have authorized in this document. 2. I may revoke this authorization, in writing, at any time by notifying the person or entity I have authorized to use or disclose information as listed above. 3. I understand that a revocation is not effective against actions taken by the person or entity named above before they received such revocation and to the extent that they have relied upon this authorization. 4. I understand that if the person or entity authorized to receive my health and clinical information is not a health care provider or health plan, the released information may be redisclosed and may no longer be protected by federal privacy regulations. 5. I may refuse to sign this form authorizing release of protected health information and my refusal to sign will not affect my ability to obtain treatment or payments except in some situations when such information is needed for payment and enrollment. 6. I may, in accordance with any applicable agency Privacy Policy, inspect or copy any information used or disclosed under this authorization upon request and obtain a copy of this form if I ask for it.

Part III. Signature, Date and Duration of Authorization/Consent:

Form with fields for Signature of Individual or Representative, Date, Print name of Individual or Representative, Representative's relationship to Individual, and This Authorization Expires: (insert date or event)

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION This information is being requested pursuant to Mental Hygiene Law §13.15 for the purpose of promoting programs and services for the benefit of individuals with developmental disabilities. Failure to provide this information will result in your name and/or image(s) not being used for publication purposes. This information will be maintained by the OPWDD Public Information Officer or his/her designee, at OPWDD, 44 Holland Ave., Albany, NY 12229. For further information relating to the Personal Privacy Protection Law call (518) 454-7700.

A copy of this signed form shall be provided to the Individual or Representative.