VANDERHEYDEN
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MORE THAN 185 YEARS

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Authorization for Release of Information

Name: _____ **DOB:** _____

This authorization must be completed by the individual or his/her personal representative to use/disclose/obtain protected health information (for treatment, payment, or health care operations purposes), in accordance with State and Federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

I, _____ authorize Vanderheyden to:

Obtain Information-

Disclose Information-

Information to be obtained/disclosed:

	Treatment goals		Discharge summary/discharge plan		Complete medical records
	Safety plans/behavior management plans		Description of progress and prognosis		Medical history and physical consultation reports.
	Psychiatric evaluation		Assessment/Screening		Individualized Education Plan
	Medication management		Educational/psychological testing		Laboratory tests
	Psychosocial assessment		Other:		

The purpose of obtaining or disclosing information:

	To provide ongoing communication with referring agency		To convey treatment recommendations and progress		To complete an evaluation (alcohol/drug, psychiatric, psychological, etc.)
	To contact in case of emergency		To maintain continuity of care		To provide ongoing treatment aftercare
	For treatment planning purposes		Other:		

This consent will remain in effect until discharge from Vanderheyden's CFTSS program. In order to revoke this authorization, a request must be completed in writing.

I hereby permit the use or disclosure of the above information to the person/organization/program(s) identified above. I understand that:

- Only this information may be used/obtained/disclosed as a result of this authorization.
- This information is confidential and cannot be legally be disclosed without my permission.
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
- I have the right to revoke this authorization at any time. My revocation must be in writing on the form provided to me by Vanderheyden. 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 acted because of my earlier authorization.
- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Vanderheyden, nor will it affect my eligibility for benefits.
- I have the right to inspect and copy my own protected health information to be used and/or disclosed as stated by law and or regulation.
- I have the right to receive a copy of this release of information.

_____	_____	_____	_____
Signature of Individual	Parent/Guardian/Authorized Rep	Signature of Witness	Date:

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CFTSS Authorizations

In the course of providing the best possible care for your child when receiving services in Vanderheyden's Children Family Treatment Support Services (CFTSS) Program. Many situations arise where parental consent is advisable or necessary. Please check the box next to each of the following paragraphs and sign your name at the end.

_____ _____

Youth Name: **Date of Birth:**

I hereby grant permission for use of any photograph or videography of my child to appear in website, public relations brochures, pamphlets, video tapes, booklets, and exhibits compiled and used by Vanderheyden. The identity of my child will not be disclosed but he/she may be identified as a service recipient.

____ **YES** ____ **NO**

I hereby give permission for my child to participate in any police agency investigation of assault, sexual abuse, or other crime committed against my child or other persons/property. I understand that such information concerning any such investigation will be made available to me by Vanderheyden.

____ **YES** _____ **NO**

I hereby give permission for my child to participate in recreational programs including activities in the community. ___ Swimming _____ Troy Boys/Girls Club ___ YMCA ____ Library

_____ **YES** _____ **NO**

I understand that this authorization will remain in effect until discharge from Vanderheyden's CFTSS program. In order to revoke this authorization, a request must be completed in writing.

_____ _____ _____

Print Full Name Parent/Guardian/Authorized Representative Date

_____

Witness

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Consent for Child's Emergency Medical Care
(By Parent/Guardian/Authorized Representative)

I, _____, hereby give my consent for emergency medical care to the child listed below while under the care of Vanderheyden, or any person or agency acting as the agent of Vanderheyden.

This medical care includes emergency room treatment which in the opinion of the physician, dentist, or psychiatrist treating the child listed are deemed necessary or advisable and/or is prescribed by such physician, dentist, or psychiatrist.

This includes the right, in case of an emergency to admit for hospitalization and to administer necessary treatment, including surgery whenever such treatment is deemed medically necessary.

_____ _____ _____
Individual Name Date of Birth Religion

_____ _____ _____
Managed Care Organization Insurance ID/CIN # **Social Security Number(Required)**

_____ _____
Primary Care Physician Phone Number and Address

Emergency Contact Information:

Name: _____

Address: _____

Phone Number: _____

Email Address: _____

Relationship to identified youth: _____

Preferred Hospital: _____

This consent will remain in effect until discharge from Vanderheyden's CFTSS program. In order to revoke this authorization, a request must be completed in writing.

_____ _____
Parent/Guardian/Authorized Representative Signature: **Printed Name:**

_____ _____
Witness **Date**

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Notice of Privacy Practices

Vanderheyden

THIS NOTICE DESCRIBES HOW HEALTH AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Our Commitment to You: We at Vanderheyden understand that the information we collect about you and your health is personal. Keeping your health information confidential and secure is one of our most important responsibilities.

We keep a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. We are committed to protecting your health information and to following all state and federal laws regarding the protection of your health information.This notice tells you how we may use or release your health information. It also tells you about your rights and requirements concerning the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to health information about you
- Follow the terms of the notice that is currently in effect
- If you have any questions about this notice, please contact the Assistant Executive Director at (518) 283-3458, ext. 11.

2. Who will follow this notice: This notice describes the practices of Vanderheyden and that of:

- Any student or member of a volunteer group we allow to help you while you are in our care

3. Your Health Information Rights:

You have the following rights regarding health information we have about you:

RIGHT to Inspect and Obtain Copies: You have the right to inspect and obtain a copy of health information that may be used to make decisions about your care. Usually, this includes medical and billing records. It does not include information that is needed for civil, criminal, or administrative actions or proceedings. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

- To inspect or obtain a copy of health information that may be used to make decisions about you, you must submit your request in writing to the Associate Executive Director.
- We may deny your request to inspect and obtain a copy in very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. The Medical/Clinical Team will review your request and the denial. The person(s) conducting the review will not include the person who denied your request. We will comply with the outcome of the review.

RIGHT to Amend: If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend that information. You have the right to request an amendment for as long as the information is kept by or for us.

- To request an amendment, your request must be made in writing and submitted to Associate Executive Director. In addition, you must provide a reason that supports your request.

RIGHT to an Accounting of Disclosures: You have the right to request a list of information releases that we have made of your health information. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

RIGHT to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for the purpose of treatment, payment, or health care operations. You also have the right to request that we restrict or limit health information about you that we may use or disclose to someone who is involved in your care or the payment for your care, such as a family member. Please be aware that we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

RIGHT to Request Confidential Communications: You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. For example, you can ask that we only contact you at a certain phone number or by mail.

RIGHT to a Paper Copy of this Notice: You have a right to a paper copy of this notice. You

- May ask us to give you a copy of this notice at any time. Even if you have agreed to receive
- This notice electronically, you are still entitled to a paper copy of this notice.
- You may obtain a copy of this notice at our website, www.vanderheydenhall.org

Use or Disclose of Your Health Information:

For Treatment: Caregivers, such as nurses, doctors, therapists and social workers, may use your health information to determine your plan of care. Individuals and programs within Vanderheyden Hall may share health information about you to coordinate the services you may need, such as clinical examinations, therapy, nutritional services, medications, hospitalization, or transfers or referrals for follow-up care. We may use health information about you to provide you with treatment or services.

For Payment: Vanderheyden may release information about you to your health insurance carrier or agency responsible for paying for your care, i.e. DSS to obtain payment for our services. For example, we may need to give your health plan information about a clinical exam or medications that you received so your health plan will pay us for treatment or services we provided. We may also share your information, when appropriate, with other government programs such as Medicaid to determine if you are eligible for, or to coordinate, your benefits, entitlements, and payments. We may need to disclose a limited amount of information about you to explore your financial situation for possible sources of payment for your care, but we will only do so as permitted under law. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

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For Operations: Vanderheyden may use and release information about you to ensure that the services and benefits provided to you is appropriate and are high quality. For example, we may use your information to evaluate our treatment and service programs or to evaluate the services of other providers that use government funds to provide health care services to you. We may combine health information about many individuals to research health trends, or determine what services and programs should be offered, or whether new treatments or services are useful. We may share your health information with our business partners who perform functions on our behalf.

To Keep You Informed: Unless you provide us with alternative instructions, we may contact you about reminders for treatment, medical care, or health check-ups. We may also contact you to tell you about health-related benefits or services that may be of interest to you or to give you information about your health care choices.

Business Associates: We provide some services through contracts with business associates so that they can perform the tasks that we have assigned to them. To protect your health information, we require the business associates to appropriately safeguard health information.

To Other Government Agencies Providing Benefits or Services: We may release your health information to other government agencies that are providing you with benefits or services when the information is necessary for you to receive those benefits or services.

As Required by Law: We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may release your health information if it is necessary to prevent a serious threat to your health or safety or to the health and safety of the public or another person.

For Public Health Activities: We may disclose health information about you to public health agencies, subject to the provision of applicable state and federal law, such as prevention or to control disease, injury or disability; child abuse or neglect; reactions to medications or problems with products to the Food and Drug Administration (FDA).

For Law Enforcement: We may release health information to a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or other similar process
- To identify or locate a suspect, fugitive, material witness, or missing person about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About criminal conduct at the agency
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

Medical Examiners and Others: We may release health information to a coroner or medical examiner to carry out their duties. If you are an organ donor, we may release your health information to an organization that help with organ eye, or tissue donation or transplantation.

National Security and Protection of the President: We may release your health information to an authorized federal official or other authorized persons for purposes of national security, for providing protection to the President, or to conduct special investigations, as authorized by law.

For Privacy Violations	**For Additional Copies or More Privacy Information**
Jenny Wiegert, Director of Quality Assurance	**Maura Psoinos, Vice President of Community Services**
Vanderheyden, Inc.	**Vanderheyden Inc.**
PO Box 219, Route 355 Wynantskill, NY 12198	**1801 6th Avenue Troy NY 12180**
(518)-283-6500 ext. 267	**(518)-286-7641**

Inability to Obtain Acknowledgement: If the individual served or their parent or personal representative refuses to sign this form or it is otherwise not possible to obtain an acknowledgement of receipt of the Notice of Privacy Practices, please identify the good faith efforts made to obtain the acknowledgement and the reasons why the acknowledgement was not obtained:

☐ Individual/representative refused to sign Acknowledgement
☐ Individual/representative unable to sign Acknowledgement
☐ Other (explain): _____

Name of Individual/representative: _____

Signature of Person who attempted to obtain Acknowledgement: _____

Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices for Vanderheyden

_____ _____

Name of Individual Served

Signature (Individual, parent or personal representative and relationship)

Date: _____

This document may be mailed or faxed to Vanderheyden Fax number is 518-283-7156

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CFTSS Cancellation Policy

Updated 4/2023

A cancelled appointment affects three people: you, the service provider, and another client who could have potentially used your time slot. CFTSS services are scheduled in advance and are reserved exclusively for our clients. When a session is cancelled without adequate notice, we are unable to fill the time slot by offering it to another client on the waiting list.

It is likely, at some point, you might forget about an appointment, or something will come up in your schedule that will result in you missing a scheduled appointment, such as being on vacation, your car breaking down, or getting stuck at work. You or your child may suddenly become sick, and have a to go to a doctor's appointment. There are many unavoidable things that present themselves.

Should a youth or family miss/cancel three scheduled appointments within a two-month period (8 weeks), the therapeutic relationship for the missed/cancelled service will be terminated. If a youth/family is engaged in other CFTSS services, full discharge from the program will be evaluated on a case-by-case basis. If a youth/family are discharged from the Vanderheyden CFTSS program, Vanderheyden can offer contact information for local agencies that provide an array of CFTSS services.

If you have any questions or concerns about this policy, please feel free to reach out to Anna Carey, Assistant Director of CFTSS. She can be reached by phone (518-308-9633 or 518-286-7630) or by email acarey@vanderheyden.org

Your signature below indicates you have read and understand this policy. Failure to adhere to the policy could result in your discharge from Vanderheyden's CFTSS program. Your signature below indicates agreement with this policy and as an acknowledgement that you have been offered a copy of this document.

_____
Client Name

_____ _____
Client Signature Date

_____ _____
Parent/Guardian/Representative Signature Date

_____ _____
Witness Date