VANDERHEYDEN
Giving new life to youth, adults and families
FAMILY FOCUSED • TRAUMA INFORMED • COMMUNITY BASED
MORE THAN 190 YEARS

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		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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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 circle your response for the following paragraphs and sign your name at the end.

Youth Name:_____ Date of Birth:_____

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, or psychiatrist treating the child listed are deemed necessary or advisable and/or is prescribed by such physician 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. Parent/Guardian/Representative would be notified immediately should emergency medical care be necessary.

YES **NO**

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**

Having a shadow provides new Vanderheyden staff with the opportunity to observe and learn about the fundamentals of CFTSS services. Through this on-the-job training, the shadowing staff builds work-based experience. All Vanderheyden programs acquaint staff with working conditions and give new staff the opportunity for continued individual growth and of the CFTSS program.

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.

_____ _____
Parent/Guardian/Representative Signature: 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 1/2025

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

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Vanderheyden Telemental Health Services Informed Consent

Vanderheyden is committed to providing services that are accessible to clients and their families. We recognize that, in certain circumstances, in-person face -to face visits may not be the preferred or most optimal modality for therapy visits to occur. As an alternative, Vanderheyden is able to offer Telemental Health visits via a secure HIPAA-compliant platform (Zoom for Healthcare or Doxy.me). All persons receiving services must be afforded the opportunity to provide informed consent to participate in any services utilizing Telemental Health Services.

This informed consent includes the following:

1. Telemental Health is defined as the use of two-way real-time interactive audio and video equipment to provide and support mental health services at a distance. Such services do not include a telephone conversation, electronic mail message, or facsimile transmission between a provider and a recipient, or a consultation between two professionals or clinical staff.
2. Clients have the right to refuse Telemental Health Services.
3. Clients who decline treatment via Telemental Health will need to travel to an authorized Clinic location to receive in-person services. Every effort will be made to provide clients with a timely in-person appointment. However, depending on availability, a delay in service delivery may result.
4. During certain circumstances (i.e. a public health emergency), there may be risks associated with receiving services in a Clinic setting. Clients who opt to receive in-person services under these circumstances will be doing so at their own risk.
5. Clients who wish to verify a Telemental Health Practitioner ' s professional license may do so by visiting the NYSED Office of the Professions website: http://www.op.nysed.gov/opsearches.html
6. Telemental Health sessions will not be recorded.
7. Clients receiving Telemental Health services will be billed in accordance with the rates and fees established by their insurance provider. This may require the payment of a co-pay or deductible.

Clients receiving Telemental Health services have the following rights:

1. Clients have the right to be made aware of the role and license information of the Telemental Health Practitioner at the distant/hub site, as well as qualified mental health professional staff at the originating/spoke site who are responsible for follow-up or on-going care (if applicable).
2. Clients have the right to be made aware of the location of the distant/hub site and to have all questions regarding the equipment, the technology, etc. addressed. The home addresses of practitioners who are operating remotely from an approved site will not be disclosed.
3. Clients have the right to have appropriately trained staff immediately available to him/her while receiving the Telemental Health Service to attend to emergencies or other needs.
4. Clients have the right to be informed of all parties who will be present at each end of the Telemental Health transmission.
5. If the recipient is a minor, the recipient and his or her parent or guardian shall be given the opportunity to provide input regarding who will be in the room with the recipient when Telemental Health services are provided.
6. Clients receiving Telemental Health services have the same right to confidentiality as required by Mental Hygiene Law Section 33.13 and 45 CFR Parts 160 and 164 (HIPAA Security Rules). This right to confidentiality includes, but is not limited to, written clinical/medical records, the actual transmission of the service, and any other electronic records, as well as the spaces occupied by the recipient at the originating/spoke site and the practitioner at the distant/hub site.
7. All Telemental Health services will be performed on dedicated secure transmission linkages, and will employ acceptable authentication and identification procedures by both the sender and the receiver

Telehealth Acknowledgement and Agreement

By signing below, clients are acknowledging that they have received notice of informed consent and recipient rights, and that they are voluntarily agreeing to receive services via Telemental Health, as deemed appropriate and as agreed upon between the client and the practitioner.

Client Name:_____**Signature:**_____
Date:_____

For clients under the age of 18, the parent or guardian acknowledges that they are giving consent for the youth to receive services via Telemental Health, as noted above.

Parent/Guardian Name:_____
Parent/Guardian Signature:_____ **Date:**_____

Acknowledgement of Receipt of CFTSS/CMHRS Youth & Family Handbook

By signing this form, I acknowledge that I have been provided with a copy of the CFTSS/CMHRS Youth and Family Handbook for Vanderheyden.

Individual Served in CFTSS Program: _____

_____ _____

Individual Signature: **Date:**

_____ _____

Parent/Guardian/Representative Printed Name: **Date:**

_____ _____

Parent/Guardian/Representative Signature: **Date:**