RISE Above

Residential Rehabilitation Program

Our Focus

- Provide a structured, supportive environment for individuals in recovery from substance use disorders.
- Provide a course of rehabilitative services in a safe and supportive recovery environment with staffing to provide monitoring and case management services.

Eligibility & Cost

Eligibility is determined by the OASAS LOCADTR. Program costs are often covered by the resident's county of origin Department of Social Services pending the residents does not have assets. Coming to RISE Above does not make you a Saratoga resident.

Residential Treatment

RISE Above is a residential substance use disorder program. Residents develop person-based treatment goals and work towards attaining those goals. Our staff provides residents with individual and group therapy, peer support, structured activities and recreation, Medical and psychiatric assessments, Medication management and psychosocial interventions.

Rise Above Admission Agreement

Rise Above is a Substance Use Disorder Residential Reintegration Program licensed by the Office of Alcoholism and Substance Abuse Services. The monthly program fee entitles the client to the following services:

1. Food and shelter in a safe and healthy environment, free of alcohol and drugs.
2. Education and assistance with daily living skills.
3. Credentialed Alcoholism and Substance Abuse Counselors, 24-hour supervision from supportive staff.
4. Assistance with budgeting and money management.
5. Coordination of services with other agencies, including help with how to navigate using community resources.
6. Support and guidance in establishing social relationships and sober supports.
7. Advocacy support to meet both mental and physical needs.
8. Crisis intervention.
9. Practice in conflict resolution, goal setting and stress management.
10. Individualized treatment for chemical addiction, discharge planning, and appropriate aftercare referrals and plans. However, while program staff provides residents with every known housing resource, it is the resident's responsibility to pursue housing for aftercare.

I understand that my admission is voluntary, and that I will be expected to cooperate with Staff and adhere to the following conditions of stay:

1. Remain alcohol and drug free.
2. Follow the rules and guidelines of the program as set forth in the program handbook.
3. Adhere to pass and curfew limits and expectations.
4. Participate in groups and individual counseling sessions.
5. Work with Primary Counselor to develop my ongoing treatment plans and goals for recovery with a focus on self-sustaining reintegration into independent living. Work actively to meet these goals.
6. Advise Staff of medical or mental health concerns and seek care as needed and recommended. I understand that the Hedgerow House Program does not have any medical staff and that any medical procedures outside of preventative care need to be approved by the agency's consulting Registered Nurse.
7. Allow my family to be contacted and informed of services which are available to them.

I recognize that the responsibility for sobriety is mine alone and that Rise Above can only provide a supportive and growth enhancing community where I can begin to make a new life. I also understand that this is an alcohol and drug free community and that any chemical use/abuse will be subject to discharge.

Resident Signature: _____ DATE: _____

Rise Above

Substance Use Disorder

Residential Rehabilitation Program

994 Route 67 Bld. B

Ballston Spa, NY 12020

(518) 288-7910 FAX (518) 288-7214

SCREENING PACKET for RESIDENTIAL REHABILITATION

OASAS REGULATION 820.3 (Definitions) (C) "REHABILTATION" PROVIDES A STRUCTURED ENVIRONMENT FOR PERSONS WHOSE POTENTIAL FOR INDEPENDENT LIVING IS SERIOUSLY LIMITED DUE TO SIGNIFICANT FUNCTIONAL IMPAIRMENT INCLUDING SOCIAL, EMPLOYMENT, COGNITIVE AND ABILITY TO FOLLOW SOCIAL NORMS THAT REQUIRES RESTRUCTURING SOCIAL SUPPORTS AND BEHAVIORS IN ORDER TO DEVELOP SUFFICIENT SKILLS; THESE PERSONS REQUIRE A COURSE OF REHABILITATIVE SERVICES IN A STRUCTURED ENVIRONMNET WITH STAFFING TO PROVIDE MONITORING AND SUPPORT AND CASE MANAGEMENT.

Rise Above is a SUD treatment program determined by the LOCADTR

DATE: _____

CLIENT NAME: _____

DATE OF BIRTH: _____

LAST PERMANENT ADDRESS: _____

PHONE #: _____

SS #: _____

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NAME: AGE: DAYS SOBER:

CLEAN DATE:

Please explain why you were referred to this program:

Do You believe you need this level of care?:

CHEMICAL USE HISTORY

Chemical Used	Age first Use	Frequency of Use	Greatest Amount used	Date of Last use	Route of Administration
Nicotine					
Alcohol					
Marijuana					
Spice/K2					
Cocaine					
Crack					
Heroin					
Other opiates					
Hallucinogens					
Ecstasy					
Benzodiazepines					
Inhalants					
Others:					

What is your drug of choice?

Longest amount of clean time that you have even had? When was that?

Why, were there certain circumstances to help with this?

Have you ever attended 12-step meetings? How often?

Date of last time attended? Do you have a sponsor?

Do you believe in a high power?

Describe a typical day of drinking and or getting high?

Do you or have you ever experienced additions in any other forms, such as sex, shopping, food, etc?
If yes, please explain>

In regard to gambling: Have you ever had to lie to people important to you about how much money you gambled?

Have you ever felt the need to bet more and more money?

Have you ever received treatment for these other addictions?

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NICOTINE USE HISTORY

Do you currently use nicotine or tobacco products?

Have you even been a nicotine or tobacco user? For how long?

Have you ever made a serious attempt to stop? If so, how?

TREATMENT HISTORY

Please list all treatment facilities that you have attended including detox, rehab and outpatient

Treatment facility	Dates and for how long?	Completed the program?

FAMILY HISTORY

Is there any family history of drug abuse? If so, Who?

Siblings:

Parents:

Children:

Aunt and Uncles:

Grandparents:

Is there any family history of mental health issues? If so, Who?

Did family alcohol or drug abuse affect your childhood?

Do your parents have an intact marriage?

If not, how old were you when your parents marriage dissolved?

Are any family members currently in treatment or recovery?

If yes, please give details:

Do you have any children? Please list names and ages.

Where do your children currently stay?

Do you have visitation rights?

How often do you typically see your children?

Have you ever been involved with Child Protective Services? If yes, please describe:

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Do you currently have contact with your family?

If not, how long has it been since you have had contact with them?

How is your relationship with your family?

Parents?

Siblings?

Children?

Significant other?

Do your family support your recovery efforts?

Do you want them to be involved in your recovery?

How would you describe your childhood?

Have you ever been married?

Are you currently in a relationship? How long?

How would you describe your current relationship?

Medical History

Where and when was your last physical examination?

Do you currently have any medical or dental problems? If so, describe:

Medications:

Please list medications and dosage:

Have you ever been in the hospital or Emergency Room in the past 6 months? If so, please describe with dates:

Mental Health

Have you ever talked to a psychiatrist, psychologist, therapist, or counselor about emotional problems?

Who? When:

Have you ever been advised to take medication for depression, anxiety, hearing voices or another emotional problem?

When? For what?

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Have you ever heard voices no one else could hear or seen objects, which others could not see?
Were you under the influence at the time?

Have you ever been depressed for weeks at a time, lost interest, or pleasure in most activities, had trouble concentrating and making decisions?

Have you ever thought about harming or killing yourself? If so, please explain if you had a plan and what that plan was?

How far into the plan did you get?

Have you attempted to kill or harm yourself in any way?

Were you under the influence at the time of the attempt?

Have you ever had nightmares or flashbacks as a result of being involved in some traumatic event? Such as, war, fire, domestic violence, rape, car accident.

Have you ever experienced any strong fears such as crowds, being alone, dirt or germs?

Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior?

Was there ever a period in your life when you spent a lot of time worrying or thinking about gaining weight, becoming fat, or controlling your eating?
Please explain:

Have you ever had a period of time when you were so full of energy and your ideas came very rapidly?
When you talked non-stop? When you needed little sleep? Believed you could do almost anything?

Have you ever been diagnosed or told that you have a mental health problem?
If so, what diagnosis? When?
From Whom?

Please list all mental health services or hospitals that you have received services from:

Hospital or counseling services: Including private practices	Diagnosis or problem seen for:	Dates attended

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Have you taken any mental health medications in the past? If so, please describe:

Medication	For What?	When?

Legal History

Please list all arrests whether you were found guilty or not:

Charges:	Date of arrest:	What town or county:	Outcome:

How many times have you been arrested in the past 6 months?

How many days have you spent in jail in the past 6 months?

Have you ever been arrested for arson, assault, or any sexual related crimes?

Do you currently have pending charges? If so, Where?

What are the charges?

Do you have any pending court dates? When and where?

Are you on probation? County?

Probation officer's name?

When does probation end?

Are you on parole?

Parole Officer's Name? New York State?

When does your parole end?

Employment and educational History

Did you complete high School? If not, what was your highest grade completed?

Do you have your GED?

Briefly describe your high school experience?

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What was your highest level of education?

Have you attended voc-ed school? For What?

Have you attended college? Did you graduate?

What degree do you have? For what?

List your last 3 jobs and give reasons for leaving each one:

Employer	Position	Reason for leaving	How long employed

Did you have a career? In What?

Did alcohol and drug use affect your employment? In what way?

What are some of your goals while at Rise Above?

What will be some of the things that will stop you from achieving these goals?

Do you have any future plans in regard to job, school or trade?

How are your life skills? Can you cook, clean, manage your time and money?

If not, what areas do you need help in?

What do you do for fun?

What did you do for fun before the drugs and the alcohol?

How would you say your communication skills are?

Have you ever had any problems with anger or extreme defensiveness?

Who do you currently have in your life for sober support?

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Do you currently have Insurance?	Medicaid?	Medicare?	Other?
If you have Medicaid, what is your ID number?			
Do you currently receive assistance from the Department of Social Services?			
If so, what county?			
Any additional comments that might help us get to know you better:			

Rise Above

994 Route 67 Bldg. B, Ballston Spa, NY 12020

(518) 288-7910 (P) (518) 288-7214 (F)

CONSENT TO OBTAIN & RELEASE INFORMATION

Give a copy of the form to the patient: Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

I, _____ do hereby consent to and authorize:
Rise Above of Rise Support Services to obtain and release to :

EMERGENCY CONTACT: _____
(Name of person or Facility) RELATIONSHIP

_____
(Address and Phone number)

The following information:

X Presence in treatment (including admission and discharge dates)

- ☐ Diagnosis, brief description of progress and prognosis
- ☐ Medical History and physical
- ☐ Intake assessment
- ☐ Psychosocial assessment
- ☐ Treatment Plan (problems, strengths, identification, goals)
- ☐ Discharge Summary
- ☐ Aftercare Plan
- ☐ Other

This information is needed for the following purposes:

- ☐ To complete an alcohol evaluation
- ☐ To provide ongoing communication with referring agency
- ☐ To provide ongoing treatment/aftercare
- ☐ To obtain insurance, employment or government benefits
- ☐ To enable judges, attorneys, probation/parole officers to support treatment goals
- ☐ To coordinate treatment efforts with family/concerned persons
- ☐ To coordinate treatment and aftercare efforts with employers

X Others _____

I, the undesigned have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. The consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1196 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: One Year from Date of Signing

Note: Any information released through this form will be accompanied by the form prohibition on Redisclosure of the Information Concerning Alcoholism /Drug Abuse Patient (TR-1 A-4400)

_____ _____

Client Signature Date

NOTE: You must also initial the Individual Authorization sheet in your chart.

Rise Above

994 Route 67 Bldg. B, Ballston Spa, NY 12020

(518) 288-7910 (P) (518) 288-7214 (F)

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I, _____ do hereby consent to and authorize:
Rise Above of Rise Support Services to obtain and release to :

Saratoga Hospital/Mental Health Unit
(Name of person or Facility)
211 Church Street, Saratoga Springs, NY 12866 P: 518-587-3222
(Address and Phone number)

The following information:

- X Presence in treatment (including admission and discharge dates)
- X Diagnosis, brief description of progress and prognosis
- X Medical History and physical
- ☐ Intake assessment
- ☐ Psychosocial assessment
- ☐ Treatment Plan (problems, strengths, identification, goals)
- ☐ Discharge Summary
- ☐ Aftercare Plan
- ☐ Other

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- ☐ To complete an alcohol evaluation
- ☐ To provide ongoing communication with referring agency
- X To provide ongoing treatment/aftercare
- ☐ To obtain insurance, employment or government benefits
- ☐ To enable judges, attorneys, probation/parole officers to support treatment goals
- ☐ To coordinate treatment efforts with family/concerned persons
- ☐ To coordinate treatment and aftercare efforts with employers
- ☐ Others _____

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_____ _____

Client Signature Date

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RISE

Rise Above

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I, _____ do hereby consent to and authorize:
Rise Above of Rise Support Services to obtain and release to :

Saratoga County Mental Health Center/Saratoga County Alcohol &Substance Abuse Services/Saratoga County PROS
(Name of person or Facility)

135 South Broadway, Saratoga Springs, NY 12866 P: 518-587-8800
(Address and Phone number)

The following information:

- X Presence in treatment (including admission and discharge dates)
- X Diagnosis, brief description of progress and prognosis
- X Medical History and physical
- X Intake assessment
- X Psychosocial assessment
- X Treatment Plan (problems, strengths, identification, goals)
- X Discharge Summary
- X Aftercare Plan
- ☐ Other

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- ☐ To obtain insurance, employment or government benefits
- ☐ To enable judges, attorneys, probation/parole officers to support treatment goals
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- ☐ To coordinate treatment and aftercare efforts with employers
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_____ _____
Client Signature Date

NOTE: You must also initial the Individual Authorization sheet in your chart.

Rise Above

994 Route 67 Bldg. B, Ballston Spa, NY 12020

(518) 288-7910 (P) (518) 288-7214 (F)

CONSENT TO OBTAIN & RELEASE INFORMATION

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I, _____ do hereby consent to and authorize:
Rise Above of Rise Support Services to obtain and release to :

O'Brien's Pharmacy
(Name of person or Facility)

4 Front Street, Ballston Spa, NY 12020 P: 518-885-7330 F: 518-885-7460
(Address and Phone number)

The following information:

- X Presence in treatment (including admission and discharge dates)
- ☐ Diagnosis, brief description of progress and prognosis
- X Medical History and physical
- ☐ Intake assessment
- ☐ Psychosocial assessment
- ☐ Treatment Plan (problems, strengths, identification, goals)
- ☐ Discharge Summary
- X Aftercare Plan
- X Other

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- ☐ To provide ongoing communication with referring agency
- X To provide ongoing treatment/aftercare
- ☐ To obtain insurance, employment or government benefits
- ☐ To enable judges, attorneys, probation/parole officers to support treatment goals
- ☐ To coordinate treatment efforts with family/concerned persons
- ☐ To coordinate treatment and aftercare efforts with employers
- ☐ Others _____

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Client Signature Date

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Rise Above

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I, _____ do hereby consent to and authorize:
Rise Above of Rise Support Services to obtain and release to :

Saratoga County Department of Social Services
(Name of person or Facility)

152 West High Street, Ballston Spa, NY 12020 P: 518-885-4144 F: 518-884-4251
(Address and Phone number)

The following information:

- X Presence in treatment (including admission and discharge dates)
- X Diagnosis, brief description of progress and prognosis
- X Medical History and physical
- X Intake assessment
- ☐ Psychosocial assessment
- ☐ Treatment Plan (problems, strengths, identification, goals)
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- ☐ To coordinate treatment and aftercare efforts with employers
- ☐ Others _____

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_____ _____

Client Signature Date

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RISE

Rise Above

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(518) 288-7910 (P) (518) 288-7214 (F)

CONSENT TO OBTAIN & RELEASE INFORMATION

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I, _____ do hereby consent to and authorize:
Rise Above of Rise Support Services to obtain and release to :

DSS County of Orgin _____
(Name of person or Facility)

_____
(Address and Phone number)

The following information:

- X Presence in treatment (including admission and discharge dates)
- X Diagnosis, brief description of progress and prognosis
- X Medical History and physical
- X Intake assessment
- ☐ Psychosocial assessment
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_____ _____
Client Signature Date

NOTE: You must also initial the Individual Authorization sheet in your chart.

Office of Alcoholism and Substance Abuse Services

NYS Office of Alcoholism and Substance Abuse Services
Authorization for Release of Behavioral Health Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

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

1. This authorization may include disclosure of all of my health information, including where applicable, my federal social security number (for record matching purposes only), any and all information relating to ALCOHOL and DRUG TREATMENT and HIV/AIDS-RELATED information. In the event the health information described below includes any of these types of information I specifically authorize release of such information to the New York State Office of Alcoholism and Substance Abuse Services (OASAS).

   _____ If you initial this line, HIV-AIDS RELATED information can also be released to OASAS. You do not have to initial this line.

   _____ If you initial this line, your Social Security Number can also be released to OASAS. You do not have to initial this line.

2. With some exceptions, health information once disclosed may be redisclosed by the receiving entity. If I am authorizing the release of my federal social security number, HIV/AIDS-related, alcohol or drug treatment, the receiving entity is prohibited from redisclosing such information or using the disclosed information for any purpose other than the purpose indicated by this authorization without my further 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 Releasing and Exchanging this Information:

6. Name and Address of Entities to whom this Information will be Disclosed and Exchanged:

   NYS Office of Alcoholism and Substance Abuse Services, 1450 Western Avenue, Albany, New York 12203

   I authorize the above listed Entity to inform the New York State Office of Alcoholism and Substance Abuse Services (OASAS) of my enrollment in this treatment program so that the quality of the services I receive may be evaluated, I also consent to all necessary communications between this facility and OASAS relative to my past alcohol and/or substance abuse treatment history; current and proposed treatment services.

7. The Purpose of this disclosure is to comply with implementation of New York's Medicaid redesign initiative and to comply with mandatory federal reporting requirements. By accepting the information covered by this consent into the NYS OASAS Client Data System, NYS OASAS acknowledges that this information may not be redisclosed per 42 CFR 2.32 – Prohibition on redisclosure.

8. My health information may be disclosed for a period of three (3) years from the last date of service, or until revoked.

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.

_____ _____
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

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.

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT TO RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

Revoked On:_____ Staff Initials:_____

Patient's Last Name	First	M.I.
Case Number		
Facility	Unit	

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED

All information necessary to investigate any alleged incident(s) of abuse or neglect, or other significant incidents, in which I may be named or am otherwise relevant.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION.

1) I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS) including its Bureau of Special Hearings, and the NYS Justice Center for the Protection of People with Special Needs (JC) including its Vulnerable Persons Central Register (VPCR) for the purpose of investigating or making determinations regarding any alleged incident(s) of abuse or neglect, or other significant incidents, in which I might be named or am otherwise relevant.

2) If I am a minor (under 18), I additionally consent to this program, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS) and the Justice Center for the Protection of Vulnerable Persons (JC) providing notification to my parent or legal guardian regarding any alleged incident(s) of abuse or neglect, or other significant incidents, in which I might be named or am otherwise relevant.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose and obtain such information as herein specified. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

Time period, event or condition extending period specified above: Completion of an investigation by the Justice Center into an allegation of abuse or neglect, or other significant incident, pursuant to Chapter 501 of the Laws of 2012 and determination of a proceeding under NY Social Services Law Article 6, title 6.

_____

_____

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____ (Signature of Patient)

_____ (Print Name of Patient)

_____ (Date)

_____ (Signature of Parent/Guardian)

_____ (Print Name of Parent/Guardian)

_____ (Date)

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT TO RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT
LOCADTR ASSESSMENT

Revoked On: _____ Staff Initials: _____

Patient's Last Name	First	M.I.
Case Number		
Facility	Unit	

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED:

All information necessary to complete a personalized Level of Care for Alcohol and Drug Treatment Referral "LOCADTR" assessment.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION:

I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the OASAS-Certified treatment facility identified above, and Payer / Managed Care Plan _____ _____ of my clinical treatment including information from the OASAS Client Data System (CDS) and my Social Security Number.

I understand that the level of care determination assessment will only be shared with me, the OASAS treatment facility, and Payer / Plan identified above. Unless I have given written permission to share the information with other agencies, programs or payers.

I further understand that non-personal identifying information may be evaluated so that the effectiveness of the LOCADTR assessment tool can be evaluated.

I, the undersigned, have read the above and authorize the New York State Office of Alcoholism and Substance Abuse Services and the staff of the OASAS-certified treatment facility named above to disclose and obtain such information as herein specified.

I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

_____

_____

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form.

_____
(Signature of Patient)

_____
(Signature of Parent/Guardian)

_____
(Print Name of Patient)

_____
(Print Name of Parent/Guardian)

_____
(Date)

_____
(Date)

Rise Above

994 Route 67 Bldg. B, Ballston Spa, NY 12020

(518) 288-7910 (P) (518) 288-7214 (F)

CONSENT TO OBTAIN & RELEASE INFORMATION

Give a copy of the form to the patient: Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

I, _____ do hereby consent to and authorize:
Rise Above of Rise Support Services to obtain and release to :

Medicaid MCO: CDPHP/ Fidelis/ MVP
(Name of person or Facility)

P: 518-641-3500, F: 518-641-3500 / cdecker@fideliscare.org, LOCADTR@fideliscare.org, F: 1-833-663-1608 / P: 1-800-684-9286, F: 1-885-853-4850
(Address and Phone number)

The following information:

X Presence in treatment (including admission and discharge dates)

- ☐ Diagnosis, brief description of progress and prognosis
- ☐ Medical History and physical
- ☐ Intake assessment
- ☐ Psychosocial assessment
- ☐ Treatment Plan (problems, strengths, identification, goals)
- ☐ Discharge Summary
- ☐ Aftercare Plan
- ☐ Other

This information is needed for the following purposes:

- ☐ To complete an alcohol evaluation
- ☐ To provide ongoing communication with referring agency
- ☐ To provide ongoing treatment/aftercare
- ☐ To obtain insurance, employment or government benefits
- ☐ To enable judges, attorneys, probation/parole officers to support treatment goals
- ☐ To coordinate treatment efforts with family/concerned persons
- ☐ To coordinate treatment and aftercare efforts with employers

X Others _____

I, the undesigned have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. The consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1196 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: One Year from Date of Signing

Note: Any information released through this form will be accompanied by the form prohibition on Redisclosure of the Information Concerning Alcoholism /Drug Abuse Patient (TR-1 A-4400)

_____ _____

Client Signature Date

NOTE: You must also initial the Individual Authorization sheet in your chart.

NEW YORK STATE
OFFICE OF ADDICTION SERVICES AND SUPPORTS

CONSENT TO RELEASE OF INFORMATION CONCERNING SUBSTANCE USE DISORDER TREATMENT

FOR CRIMINAL JUSTICE CLIENTS

Client's Last Name	First	MI

Client's New York State Identification Number (NYSID)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Referring Entity's Staff Member's Name:

Referring Entity's Name & Address

Referring Entity Type
- ☐ District Attorney
- ☐ Court
- ☐ Probation

- ☐ Parole - General
- ☐ Parole - Release Shock
- ☐ Parole - Release Willard
- ☐ Parole - Release Resentence

INSTRUCTIONS:
1) **SEND A COPY OF THIS COMPLETED FORM TO THE CLIENT'S TREATMENT PROVIDER;**
2) **ADD A COPY OF THIS COMPLETED FORM TO THE CLIENT'S CRIMINAL JUSTICE FILE; AND**
3) **PROVIDE A COPY OF THIS COMPLETED FORM TO THE CLIENT/DEFENDANT**

1) I, the undersigned, Client/Defendant, hereby **CONSENT** and authorize communication between the above named **Referring Entity**, my Substance Use Disorder Treatment Provider: _____

and the following: _____

_____

_____

I **CONSENT** to **DISCLOSURE OF INFORMATION** concerning my current and past individual assessment or evaluation, intake summary, diagnosis, treatment recommendation, date of admission, and status as a patient including course and level of treatment (i.e. residential, community based, individual, or group), my progress and adherence including but not limited to: my attendance at treatment, dates and results of toxicology testing, cooperation with my treatment program, prognosis, treatment completion or reason(s) for termination, date of discharge, discharge status, and discharge plan.

Such disclosure is for the **PURPOSE** of enabling the entities listed above to communicate as to my treatment needs, activities, history and adherence with my evaluation and treatment for purposes of monitoring the terms and conditions of treatment, release, care management purposes, and for carrying out other official duties; **AND**

2) I further **CONSENT** and authorize communication between and among the above named **Referring Entity** and the New York State Office of Addiction Services and Supports (**OASAS**); and OASAS to **DISCLOSE INFORMATION** to the New York State Division of Criminal Justice Services (**DCJS**), concerning admission and discharge data for the **PURPOSE** of research and program evaluation activities. I understand that any reports or studies compiled from my records disclosed pursuant to this release will not include personally identifiable information which will remain confidential and protected from further re-disclosure.

I, the undersigned, have read the above and authorize the staff of the above named disclosing entities to disclose, obtain and share such information as herein specified. I understand that, unless otherwise specified, this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, interim probation supervision, probation, parole, post-release supervision, or local conditional release or other proceeding or determination by a releasing authority under which I was referred to or otherwise agreed to treatment.

I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations 42 CFR Part 2, governing the confidentiality of substance use disorder treatment records for patients, as well as the Health Insurance Portability and AccountabilityAct of 1996 (HIPAA) 45 C.F.R. Pts. 160 &164; and that redisclosure of such information to a party other than those designated above isforbidden without additional written authorization on my part.

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____ (Print Name of Client)

_____ (Signature of Client)

_____ (Date)

Rise Above

994 Route 67 Bldg. B, Ballston Spa, NY 12020

(518) 288-7910 (P) (518) 288-7214 (F)

CONSENT TO OBTAIN & RELEASE INFORMATION

Give a copy of the form to the patient: Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

I, _____ do hereby consent to and authorize:
Rise Above of Rise Support Services to obtain and release to :

Prevention Council, Family Navigator and Healing Springs
(Name of person or Facility)

125 High Rock Ave Rear lot, blue awning, Saratoga Springs, NY 12866 518-306-3048
(Address and Phone number)

The following information:

X Presence in treatment (including admission and discharge dates)

☐ Diagnosis, brief description of progress and prognosis

☐ Medical History and physical

☐ Intake assessment

☐ Psychosocial assessment

☐ Treatment Plan (problems, strengths, identification, goals)

☐ Discharge Summary

☐ Aftercare Plan

☐ Other

This information is needed for the following purposes:

☐ To complete an alcohol evaluation

☐ To provide ongoing communication with referring agency

☐ To provide ongoing treatment/aftercare

☐ To obtain insurance, employment or government benefits

☐ To enable judges, attorneys, probation/parole officers to support treatment goals

☐ To coordinate treatment efforts with family/concerned persons

☐ To coordinate treatment and aftercare efforts with employers

X Others _____

I, the undesigned have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. The consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1196 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: One Year from Date of Signing

Note: Any information released through this form will be accompanied by the form prohibition on Redisclosure of the Information Concerning Alcoholism /Drug Abuse Patient (TR-1 A-4400)

_____ _____

Client Signature Date

NOTE: You must also initial the Individual Authorization sheet in your chart.

RISE
HEALTHY HOUSING
AND SUPPORT SERVICES

RISE Media Consent Form

Name of Individual (print): _____

Purpose of Consent: By signing this form, I am authorizing RISE Housing and Support Services, Inc. (hereinafter known as 'RISE') to record statements, interviews, photographs, videos, and any other media (hereinafter collectively known as 'recording') of the above-named individual. A recording will be used for purposes including, but not limited to, publication, promotion, and/or advertising of RISE's activities, programs, and services. The sharing of a recording may include but is not limited to use on RISE's websites, social media pages, printed advertisements, and event promotions.

Voluntary Recording: I agree that the recording was voluntarily shared and that no financial remuneration will be received for it.

Limits on Disclosure: I understand that my identifying information will be limited to my name as described under Identification Choice and the contents of the recording. This consent form does not authorize RISE to disclose protected health information other than my name, the contents of the recording, and the disclosure of my underlying health condition(s) and treatment, including substance abuse and mental health conditions.

Identification Choice: I am authorizing RISE to identify me in relation to the recording by (check the box by your selection): ☐**Full Name** ☐**First Name Only** ☐**Last Name Only** ☐**Initials** ☐**Do Not Use My Name**

Right to Revoke: I understand that I have the right to revoke this authorization at any time by providing a written request to the Compliance Officer at RISE at 127 Union Street, Saratoga Springs NY, 12866. I understand that if I choose to revoke this authorization, that revocation will become effective on the day it is received. I understand that RISE will make its best effort to remove any recordings from continued usage once the revocation is received, but that any prior uses or disclosures of my recording(s) and information will not be subject to the revocation of the authorization.

By signing below, I acknowledge that I have read and understand all the elements of this consent and I agree to its terms and conditions.

Signature of Individual (if over 18)

Signature: _____ Date: _____

OR

Signature of Parent/Legal Guardian (if under 18)

Name (Printed):_____ Date: _____

Relationship_____

Signature: _____

RISE

INDIVIDUAL AUTHORIZATION

Resident Name: _____ **ID Number:**_____

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

A representative of Rise Support Services must answer these questions completely before providing this authorization form to you. DO NOT SIGN A BLANK FORM. You or your personal representative should read the descriptions below before signing this form.

Who will disclose the information? The person(s) or class of persons authorized to disclose the information are described below.
Transitional Services Association, Inc.

Who will use and/or receive the information? The person(s) or class of persons authorized to use and/or receive the information are described below.

Please initial choices you select	Initial	Date
Emergency Contact Person(s)_____ _____		
Saratoga Hospital/Mental Health Unit		
Saratoga County Mental Health Center/ Saratoga County Alcohol & Substance Abuse Services/ Saratoga County PROS		
O'Brien's Pharmacy		
Saratoga County Department of Social Services		
Other- _____County Department of Social Services		
OASAS Client Data System		
LOCADTR Assessment		
Re-disclosure Release _____		
Justice Center Release		
Criminal Justice Release _____		
Social Security Administration		
Healing Springs: Prevention, CRPA, Comm. Center, Family Navigator		
RISE Media Release		
Other—specify name(s)_____		
Other—specify name(s)_____		
Other—specify name(s)_____		
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Other—specify name(s)______		

What information will be used or disclosed? The appropriate boxes should be checked below and the descriptions should be in enough detail so that you (or any organization that must disclose information pursuant to this authorization) can understand what information may be used or disclosed.

- ☐ The following information: Any and all relevant information regarding the person identified above as often as necessary to plan for/provide care and treatment, which may include vocation, education, training, rehabilitation, funding and financial matters

- ☐ The following HIV-related information (which is any information indicating that you have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or any information which could indicate that you have been potentially exposed to HIV):

  _____
  _____
  _____

What is the purpose of the use or disclosure? The purposes for which the information will be used or disclosed are described below. The words "at the request of the individual" is a sufficient description of the purpose when a resident initiates the authorization and chooses not to provide any further explanation of the purpose.
(1) At the request of the individual
(2) To plan for/provide care and treatment, which may include vocation, education, training, rehabilitation, funding and financial matters

When will this authorization expire? The date or event that will trigger the expiration of this authorization should be described below.
When resident is no longer receiving services from the agency

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

If you are authorizing the release of alcohol and drug-related information, such disclosure is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records.

If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have a right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the agency has already taken action based upon your authorization. To revoke this authorization, please write to Peter L. Rogers at 127 Union Street, Saratoga Springs, NY 12866.

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

_____
Signature of Resident or Personal Representative

_____
Print Name of Resident or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

CONTACT INFORMATION

The contact information of the resident or personal representative who signed this form should be filled in below.

Address:
_____
_____
_____
_____

Telephone:
_____ (daytime)
_____ (evening)

Email Address (optional):
_____

THE RESIDENT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.

RISE
HEALTHY HOUSING AND SUPPORT SERVICES

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

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

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our agency staff and affiliated health care providers that jointly provide health care services with our agency. A copy of our current notice will always be posted in our reception area. You or your personal representative may also obtain a copy of this notice by requesting a copy from our Program Directors.

If you have any questions about this notice or would like further information, please contact Sybil Newell, Executive Director at 127 Union Street, Saratoga Springs, NY 12866, (518) 587-6193 *during regular business hours.*

WHO WILL FOLLOW THIS NOTICE?

Rise Healthy Housing and Support Services. provides health care to residents jointly with physicians and other health care professionals and organizations. The privacy practices described in this notice will be followed by:

- Any health care professional or other treatment provider who treats you at any of our locations;
- All employees, health care professionals, trainees, students or volunteers at any of our locations;
- All employees, health care professionals, trainees, students or volunteers at any other agencies, hospitals or other entities that are part of an organized health care arrangement with the agency;
- Any business associates of our agency (which are described further below).

PERMISSIONS DESCRIBED IN THIS NOTICE

This notice will explain the different types of permission we will obtain from you before we use or disclose your health information for a variety of purposes. The three types of permissions referred to in this notice are:

- A "general written consent," which we must obtain from you in order to use and disclose your health information in order to treat or care for you, obtain payment for that treatment or care, and conduct our business operations. We must obtain this general written consent the first time we provide you with treatment or care. This general written consent is a broad permission that does not have to be repeated each time we provide treatment or care to you.

- An "opportunity to object," which we must provide to you before we may use or disclose your health information for certain purposes. In these situations, you will have an opportunity to object to the use or disclosure of your health information in person, over the phone, or in writing.

- A "written authorization," which will provide you with detailed information about the persons who may receive your health information and the specific purposes for which your health information may be

used or disclosed. We are only permitted to use and disclose your health information described on the written authorization in ways that are explained on the written authorization form you have signed. A written authorization will have an expiration date.

IMPORTANT SUMMARY INFORMATION

Requirement For Written Authorization. We will generally obtain your written authorization before using your health information or sharing it with others outside the agency. You may also initiate the transfer of your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke an authorization, please write to Sybil Newell at 127 Union Street, Saratoga Springs, NY 12866.

Exceptions To Written Authorization Requirement. There are some situations when we do not need your written authorization before using your health information or sharing it with others. They are:

- **Exception For Treatment, Payment, And Business Operations.** We will only obtain your general written consent one time to use and disclose your health information to treat or care for your condition, collect payment for that treatment or care, or run our business operations. In some cases, we also may disclose your health information to another health care provider or payor for its payment activities and certain of its business operations. For more information, see pages 4-5 of this notice.

- **Exception For Directory Information And Disclosure To Family And Friends Involved In Your Care.** We will ask you whether you have any objection to including information about you in our Facility Directory or sharing information about your health with your friends and family involved in your care. For more information, see page 5 of this notice.

- **Exception In Emergencies Or Public Need.** We may use or disclose your health information in an emergency or for important public needs. For example, we may share your information with public health officials at the New York State or City Health Departments who are authorized to investigate and control the spread of diseases. For more examples, see pages 5-7 of this notice.

- **Exception If Information Is Completely Or Partially De-Identified.** We may use or disclose your health information if we have removed any information that might identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" information if the person who will receive the information agrees in writing to protect the privacy of the information. For more information, please see page 7 of this notice.

How To Access Your Health Information. You generally have the right to inspect and copy your health information. For more information, please see page 8 of this notice.

How To Correct Your Health Information. You have the right to request that we amend your health information if you believe it is inaccurate or incomplete. For more information, please see page 8 of this notice.

How To Identify Others Who Have Received Your Health Information. You have the right to receive an "accounting of disclosures" which identifies certain persons or organizations to whom we have disclosed your health information in accordance with the protections described in this Notice of Privacy Practices. Many routine disclosures we make will not be included in this accounting, but the accounting will identify many non-routine disclosures of your information. For more information, please see page 9 of this notice.

How To Request Additional Privacy Protections. You have the right to request further restrictions on the way we use your health information or share it with others. We are not required to agree to the restriction you request, but if we do, we will be bound by our agreement. For more information, please see pages 9-10 of this notice.

How To Request More Confidential Communications. You have the right to request that we contact you in a way that is more confidential for you. We will try to accommodate all reasonable requests. For more information, please see page 10 of this notice.

How Someone May Act On Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

How To Learn About Special Protections For HIV, Alcohol and Substance Abuse, Mental Health And Genetic Information. Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you will be provided with separate notices explaining how the information will be protected. To request copies of these other notices now, please contact Sybil Newell at 127 Union Street, Saratoga Springs, NY 12866, (518) 587-6193.

How To Obtain A Copy Of This Notice. You have the right to a paper copy of this notice. You may request a paper copy at any time, even if you have previously agreed to receive this notice electronically. To do so, please call Sybil Newell at (518) 587-6193. You or your personal representative may also obtain a copy of this notice by requesting a copy from our Program Directors.

How To Obtain A Copy Of Revised Notice. We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. The revised notice will apply to all of your health information. We will post any revised notice in our agency reception area. You or your personal representative will also be able to obtain your own copy of the revised notice by requesting a copy from our Program Directors. The effective date of the notice will always be noted in the top right corner of the first page. We are required to abide by the terms of the notice that is currently in effect.

How To File A Complaint. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with HHS, you may contact them at 200 Independence Avenue, SW, Washington, D.C. 20201, or at 1-877-696-6775. In addition, the Federal Center for Deaf and Hearing Impaired can be contacted at 1-800-877-8339.

To file a complaint with us, please contact Sybil Newell at 127 Union Street, Saratoga Springs, NY 12866, (518) 587-6193. *No one will retaliate or take action against you for filing a complaint.*

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- information indicating that you are a resident at the agency or receiving treatment or other health-related services from our agency;
- information about your health condition (such as a psychiatric diagnosis you may have received);
- information about health care products or services you have received or may receive in the future;
- information about rehabilitation or other counseling that you may be receiving;
- information about benefits you may receive under Medicaid; or
- information about your health care benefits under an insurance plan (such as whether a prescription is covered);

when combined with:

- demographic information (such as your name, address, or insurance status);
- unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); and
- other types of information that may identify who you are.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

1. Treatment, Payment And Business Operations

With your general written consent, we may use your health information or share it with others in order to provide you with treatment or care, obtain payment for that treatment or care, and run our business operations. In some cases, we may also disclose your health information for payment activities and certain business operations of another health care provider or payor. Below are further examples of how your information may be used and disclosed for these purposes.

Treatment. We may share your health information with counselors and other treatment providers at the agency who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. A treatment provider at our agency may share your health information with another treatment provider inside our agency, or with a treatment provider at another health care facility, to determine how to diagnose or treat you. Your treatment provider may also share your health information with another treatment provider to whom you have been referred for further health care.

Payment. We may use your health information or share it with others so that we may obtain payment for your health care services. For example, we may share information about you with Medicare, Medicaid, or your health insurance company in order to obtain reimbursement for treatment or care we have provided to you, or to determine whether it will cover your future treatment or care. Finally, we may share your information with other providers and payors for their payment activities.

Business Operations. We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you. Finally, we may share your health information with other health care providers and payors for certain of their business operations if the information is related to a relationship the provider or payor currently has or previously had with you, and if the provider or payor is required by federal law to protect the privacy of your health information.

Treatment Alternatives, Benefits And Services. In the course of providing treatment to you, we may use your health information to contact you in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

Fundraising. To support our business operations, we may use demographic information about you, including information about your age and gender, when deciding whether to contact you or your personal representative to raise money to help us operate. We may also share this information with a charitable foundation that will contact you or your personal representative to raise money on our behalf.

Business Associates. We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from Medicaid or your insurance company. Another example is that we may share your health information with an accounting firm or law firm that provides professional advice to us about how to improve our health care services and comply with the law. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

We can do all of these things if you have signed a general written consent form. Once you sign this general written consent form, it will be in effect indefinitely until you revoke your general written consent. You may revoke your general written consent at any time, except to the extent that we have already relied upon it. For example, if we provide you with treatment or care before you revoke your general written consent, we may still share your health information with your insurance company in order to obtain payment for that treatment or care. To revoke your general written consent, please write to Sybil Newell at 127 Union Street, Saratoga Springs, NY 12866.

2. Facility Directory/Family And Friends

We may use your health information in, and disclose it from, our Facility Directory, or share it with family and friends involved in your care, without your written authorization. We will always give you an opportunity to object unless you are incapacitated when you first arrive at the agency (in which case we will discuss your preferences with you as soon as you regain capacity). We will follow your wishes unless we are required by law to do otherwise.

Facility Directory. If you do not object, we will include [your name, your location in our facility and your religious affiliation] in our Facility Directory while you are a resident in the agency. This directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if he or she doesn't ask for you by name.

Family And Friends Involved In Your Care. If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition here at the agency, or about the unfortunate event of your death. In some cases, we may need to share your information with a disaster relief organization that will help us notify these persons.

3. Emergencies Or Public Need

We may use your health information, and share it with others, in order to treat you in an emergency or to meet important public needs. We will not be required to obtain your general written consent before using or disclosing your information for these reasons. We will, however, obtain your written authorization for, or

provide you with an opportunity to object to, the use and disclosure of your health information in these situations when state law specifically requires that we do so.

Emergencies. We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your general written consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.

Communication Barriers. We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

As Required By Law. We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

Public Health Activities. We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury or disability. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits us to do so.

Victims Of Abuse, Neglect Or Domestic Violence. We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of such abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Product Monitoring, Repair And Recall. We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits And Disputes. We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.

Law Enforcement. We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders or laws that we are required to follow;
- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your general written consent because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- If we suspect that your death resulted from criminal conduct; or
- If necessary to report a crime that occurred on our property.

To Avert A Serious And Imminent Threat To Health Or Safety. We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

National Security And Intelligence Activities Or Protective Services. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Inmates And Correctional Institutions. If you later become incarcerated at a correctional institution or detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation. We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Coroners, Medical Examiners And Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

Organ And Tissue Donation. In the unfortunate event of your death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

Research. In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use and disclose your health information without your written authorization if we obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your written authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

4. Completely De-identified Or Partially De-identified Information.

We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" health information about you if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will *not* contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

5. Incidental Disclosures

While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other residents in the treatment area may see, or overhear discussion of, your health information.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about your medical matters.

1. Right To Inspect And Copy Records

You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request to Sybil Newell at 127 Union Street, Saratoga Springs, NY 12866. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. The standard fee is $0.75 per page and must generally be paid before or at the time we give the copies to you. We will respond to your request for inspection of records within 10 days. We ordinarily will respond to requests for copies within 30 days if the information is located in our facility, and within 60 days if it is located off site at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request.

Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead. We will also provide a written notice that explains our reasons for providing only a summary, and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

2. Right To Amend Records

If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records. To request an amendment, please write to Sybil Newell at 127 Union Street, Saratoga Springs, NY 12866.
Your request should include the reasons why you think we should make the amendment. Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement which we will include in your records. We will also include information on how to file a complaint with us or with the Secretary of the Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

3. Right To An Accounting Of Disclosures

After April 14, 2003, you have a right to request an "accounting of disclosures" which identifies certain other persons or organizations to whom we have disclosed your health information in accordance with applicable law and the protections afforded in this Notice of Privacy Practices. An accounting of disclosures does not describe the ways that your health information has been shared within and between the agency and the facilities listed at the beginning of this notice, as long as all other protections described in this Notice of Privacy Practices have been followed.

An accounting of disclosures also does not include information about the following disclosures:

- Disclosures we made to you or your personal representative;
- Disclosures we made pursuant to your written authorization;
- Disclosures we made for treatment, payment or business operations;
- Disclosures made from our facility directory;
- Disclosures made to your friends and family involved in your care or payment for your care;
- Disclosures that were incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another resident passing by);
- Disclosures for purposes of research, public health or our business operations of limited portions of your health information that do not directly identify you;
- Disclosures made to federal officials for national security and intelligence activities;
- Disclosures about inmates to correctional institutions or law enforcement officers; or
- Disclosures made before April 14, 2003.

To request an accounting of disclosures, please write to Sybil Newell at 127 Union Street, Saratoga Springs, NY 12866. Your request must state a time period within the past six years (but after April 14, 2003) for the disclosures you want us to include. For example, you may request a list of the disclosures that we made between January 1, 2004 and January 1, 2005. You have a right to receive one accounting within every 12 month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12 month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. In rare cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or government agency has asked us to do so.

4. Right To Request Additional Privacy Protections

You have the right to request that we further restrict the way we use and disclose your health information to provide you with treatment or care, collect payment for that treatment or care, or run our business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. For example, you could request that we not disclose information about a surgery you had. To request restrictions, please write to Sybil Newell at 127 Union Street, Saratoga Springs, NY 12866. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply.

We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. *However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law.* Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will

also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.

5. Right To Request Confidential Communications

You have the right to request that we communicate with you or your personal representative about your medical matters in a more confidential way by requesting that we communicate with you by alternative means or at alternative locations. To request more confidential communications, please write to Sybill Newell at 127 Union Street, Saratoga Springs, NY 12866. *We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.* Please specify in your request how you or your personal representative wish to be contacted, and how payment for your health care will be handled if we communicate with your personal representative through this alternative method or location.

ACKNOWLEDGMENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the agency and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information.

_____
Signature of Resident or Personal Representative

_____
Print Name of Resident or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority