



220 HERALD PLACE  
SYRACUSE, NEW YORK 13202  
(315) 472-7363  
FAX (315) 472-0084

DEBORAH DONAHUE  
EXECUTIVE DIRECTOR

### CONSENT FOR RELEASE OF INFORMATION

I consent to use and disclosure of protected health information about me for arranging services, treatment, payment, and health care operations as described below. This means that information about my health will be used by the staff of Onondaga Case Management Services, Inc. or disclosed to other people or organizations whenever needed to:

- Provide services to me or arrange for services by another health care provider.
- Arrange for payment for services to me.
- Operate the business of Onondaga Case Management Services, Inc.
- Enable other health care organizations that provide services to me or pay for services to me to review the quality and appropriateness of care I receive and conduct other health care operations.

I understand that information disclosed pursuant to this consent may be re-disclosed by the recipient of the information. Most health care providers and all health benefit plans are obligated to follow federal rules and state laws for protection of the privacy of your health information. But those rules and laws do not apply to all organizations.

I understand that there is no time limit on this consent.

I also understand that I may revoke this consent at any time.

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I am the person who is the subject of the health records that will be used or disclosed. I agree to use and disclosure of my health information as described in this consent.

X \_\_\_\_\_  
Signature

X \_\_\_\_\_  
Date

X \_\_\_\_\_  
Print Name

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I am the personal representative of the person whose records will be used or disclosed.

My relationship to that person is \_\_\_\_\_.

I agree to use and disclosure of the health information of (Name) \_\_\_\_\_ as described in this consent.

X \_\_\_\_\_  
Signature

X \_\_\_\_\_  
Date

X \_\_\_\_\_  
Print Name



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**Request for Restriction of  
Disclosures of Protected Health Information**

I hereby request that Onondaga Case Management Services, Inc. restrict disclosure of protected health information about \_\_\_\_\_ (name of individual) in the manner described below.

Please do not disclose protected health information to (name of person or organization).

\_\_\_\_\_  
\_\_\_\_\_.

Please do not use protected health information for the purposes listed below. organization).

\_\_\_\_\_  
\_\_\_\_\_.

I understand that Onondaga Case Management Services, Inc. is not required to agree to this request for restriction of use and disclosure of protected health information.

I am the person who is the subject of the health records that will be restricted.

X \_\_\_\_\_  
Signature

X \_\_\_\_\_  
Date

X \_\_\_\_\_  
Print Name

I am the personal representative of the person whose records will be restricted.

My relationship to that person is \_\_\_\_\_.

I agree to the restriction on the use of the health information as described in this request.

X \_\_\_\_\_  
Signature

X \_\_\_\_\_  
Date

X \_\_\_\_\_  
Print Name

X \_\_\_\_\_  
Date