Client must initial each section that applies and sign at the end. Worker must complete attestation.

Informed Consent to Collect and Record Personal Information

I consent to the Clinton County Office for the Aging saving personal information provided by me or my authorized representative in the Client Data System maintained by the New York State Office for the Aging (NYSOFA). Saving my information like this allows other agencies that use the Client Data System to see my information if a referral is made, but this will only happen with my permission.

I understand that this information is being collected to help in providing services under the State Office for the Aging and local Offices for the Aging. It also helps to identify other services that I may need. I understand that this information is needed in order for some services to be provided. The authority to provide these services and to collect my information for these purposes is found in the Older Americans Act and the New York State Elder Law.

I understand that, per New York State's Personal Privacy Protection Law, my personal information will be kept confidential. It will not be shared without my permission.

I understand what information will be recorded, the need for the information, and that there are laws and regulations protecting my information.

I understand that signing this authorization is voluntary, but that refusal to do so may limit options available to me.

Client Initial _____

Informed Consent to Refer and Share Personal Information

I request and consent to the release by Clinton County Office for the Aging of all requested records, including but not limited to, personal information, health information, and any other information concerning me that I have provided to Clinton County Office for the Aging to the following entities so they can make referrals for services that I may need, or for the purposes identified as follows:

_____

_____

_____

_____

I understand what information will be released, the need for the information and that there are laws and regulations protecting the confidentiality of this information.

I understand that signing this authorization is voluntary, but that refusal to do so may limit options available to me.

I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and in such an event may no longer be protected by federal or state law.

Client Initial _____

Informed Consent to Share Certain Information in the event of a Disaster or Emergency

In the event of a disaster or emergency, I consent to the release of information about services I receive, my housing situation and who I live with, medical equipment or services needed daily, prescription medications taken daily, special dietary needs, special communication needs, blindness or other visual impairments, and information about my general condition and mobility.

I understand that this information will only be given to those who will use it to respond to an emergency, such as government agencies, law enforcement, or those acting on their behalf if there is a disaster or emergency situation.

I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and in such an event may no longer be protected by federal or state law.

Client Initial _____

I consent to actions above where I have initialed. The authorizations provided shall not expire unless revoked.

_____ _____
Signature of individual or legal representative *Date*

_____
Individual's name (Print)

_____
If legal representative, provide name and relationship to individual

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ FOR OFFICE USE ONLY ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

ATTESTATION
To be completed by worker

I attest that informed consent, as indicated, was obtained from the above individual, who provided his/her signature above. All appropriate processes were followed, and consent was provided voluntarily.

_____ _____
Signature *Date*

_____
Print

Submit Form to Mary