NEW YORK STATE Corrections and Community Supervision **DIRECTIVE**	TITLE **Request for Information from Mental Health Agencies without Parolee Consent**		NO. 8340 DATE 11/04/2019
SUPERSEDES DOP P&P Manual Item 8340.03	DISTRIBUTION A	PAGES PAGE 1 OF 2	DATE LAST REVISED
REFERENCES (Include but are not limited to) New York State Mental Health Law 33.13	APPROVING AUTHORITY		

I. PURPOSE: To instruct Community Supervision staff in obtaining necessary information from mental health providers without the signed Release-of-Information (ROI) form.

II. POLICY: In order to enhance public safety, aid in the development of appropriate treatment plans, and ensure the personal safety of parolees living in the community, Community Supervision staff will apply under the provisions of the Mental Health and Hygiene Law 33.13 (c) (9) & (10) to obtain the necessary information when a parolee refuses to give written consent for mental health providers to release information.

III. DEFINITIONS

A. Necessary Information: Information that can be obtained without consent, which may be limited to a summary of the record, including but not limited to the following: basis for referral to the mental health agency; diagnosis upon admission and discharge; diagnosis and description of current mental condition; current course of treatment; medication and therapies; and mental health provider recommendations for future mental hygiene services, if any.

B. Parolee: Refers to any person under the authority of the Department of Corrections and Community Supervision (DOCCS) who has been granted conditional release by serving part of a sentence and who remains under the control of and in the legal custody, or a person who is serving Post-Release Supervision (PRS) in the community and who continues to be under the authority of DOCCS.

NOTE: Mental health providers may provide this information to DOCCS without client consent, but only with respect to patients who have received active treatment from the mental health agency and for parolees who are actively supervised in the community and are under the jurisdiction of DOCCS.

IV. PROCEDURE

A. Obtaining Mental Health Information

1. The Parole Officer (PO) will first advise the parolee to sign the Department of Health (DOH) form, "Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-Related Information" (Form DOH-5032) for the mental health provider to disclose the necessary information to DOCCS.
2. If the parolee refuses to sign Form DOH-5032, the PO will then case conference with the Senior Parole Officer (SPO). If necessary, the PO may initiate appropriate action as follows:

a. The SPO will send a written request to the mental health provider(s), indicating confidential treatment information is being requested pursuant to Mental Health and Hygiene Law 33.13 (c) (9) & (10).

NOTE: The SPO acts as a Chief Administrative Officer

b. The following Information must be included in the written request for information:

(1) Parolee's name (including alias, AKA, nickname, etc.)

(2) Parolee's Social Security Number (SSN)

(3) Parolee's Date of Birth (DOB)

(4) Parolee's Date of requested release

(5) Date of treatment services provided to the parolee

(6) Special conditions of release relevant to the request for mental health information

(7) Maximum expiration date

c. Include the name and telephone number and address of the PO and SPO making the request.

d. State the urgency of the request

e. State the information being requested and the specific safety or programmatic reasons for the request.

f. Advise the mental health agency that the material will be kept in a confidential file accessible only to appropriate DOCCS personnel.

NOTE: In an emergency, the Parole Officer may make an oral request only if the parolee is believed, because of mental illness, to pose an imminent threat of substantial harm to self or others. The mental health agency may provide information limited to that relating to the degree of threat a parolee poses, current course of treatment, and any clinical recommendations. When this information is requested and received verbally, it is the PO's obligation to follow up with a written letter within three business days from the date of the original request document ting the verbal request and the reason for it. The mental health agency shall confirm the content of the request and respond in writing within 10 days.

B. <u>Request for Mental Health Agency Staff to Testify at Parole Revocation Preliminary Hearings</u>

1. If testimony is required, the PO will subpoena the least number of mental health staff necessary to obtain the relevant information.

2. In cases where written mental health testimony can be used in place of actual appearances, the PO will case conference with the SPO and request such testimonies.

NOTE: Via the chain of command, staff may wish to consult with The Office of the Counsel regarding whether such written testimony may substitute for an appearance.

NOTE: If staff encounter difficulties in working with State mental health facilities or local mental health facilities, they must notify Re-Entry Services, who will contact the Bureau of Forensic Services at the Office of Mental Health for assistance.

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related 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 be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my 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 to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ (INSERT START DATE) until _____ (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

_____

For the following to be included, indicate the specific information to be disclosed and initial below.

	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

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

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. 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.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.