

Informed Consent to Capture and Record Personal Information (NY Connects)

I consent to the _____ saving personal information
(name of entity capturing)
provided by me or my authorized representative in the Statewide Client Data System maintained by the New York State Office for the Aging and in the UAS-NY Database maintained by the New York State Department of Health. This information may include, but is not limited to, personal and health information and any other information concerning me collected by _____
[name of entity].

I understand that this information is being collected to help in providing services under the New York Connects Program and to identify other services which I may benefit from. I understand that 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 any personal information saved in the databases is treated as confidential and is stored in accordance with all applicable federal and state laws.

I acknowledge that informed consent has been explained to me and that I understand the information to be recorded, the need for the information, and that there are laws and regulations protecting the confidentiality of authorized information.

I understand that signing this authorization is voluntary and that refusal to do so will have no effect on my eligibility for services, but may make it more difficult to provide these services and to make referrals on my behalf. I have the right to revoke this authorization at any time, except to the extent that action has already been taken based upon this authorization, by writing to _____
[name of entity].

Signature

Date

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