

Go-Dark Period (after 5:00 pm on Aug. 5, 2016 - Sept. 14, 2016)
Informed Consent to Refer (NY Connects) Script

Client Name (first name, last name):
Address:
Phone number:
Date:

Read the following:

Do I have your permission to release your personal information contained in the Statewide Client Data System maintained by the New York State Office for the Aging to

_____,
(Insert Agency Name/Program Name)
including what you are seeking help with?

- Yes (if in person, written consent is required)**
- No (If no): I can provide you with information for you to follow up on your own, but I will not be able to make a referral on your behalf.**

User (Worker) Signature:
User (Worker) Title :
Date:
<i>This form must be uploaded into the new Statewide Client Data System in association with the NY Connects Client Record for this individual.</i>