

New York City Department for the Aging

Last Name: _____	First Name: _____
Address: _____	Apt. Number: _____
City: _____	State: _____
Zip: _____	Home Phone: _____
Program: _____	Cell Phone: _____

Consent to Collect Data

Date Consent Provided to Collect Data: _____

I consent to having personal information provided by me or my legal representative entered into the Client Data System maintained by the New York City Department for the Aging. I understand what information will be recorded, why this information is needed, and that there are laws and regulations protecting my personal health and identifying information.

I understand that this information is being collected to help in providing services, including services funded through the New York City Department for the Aging. It also helps identify other services that I may qualify for. I understand that this information is needed in order for some services to be provided.

I understand that signing this authorization is voluntary and can be revoked at any time. If I refuse to sign this authorization, the above named service provider will not be able to help by making referrals for me. Information can be given to me to follow-up on my own.

Client Initial: _____

Consent to Share Emergency Preparedness Information

Date of Emergency Preparedness Consent: _____

In the event of an emergency, I consent to the release of my information contained in the Emergency Preparedness Form and have received a copy of this form. I understand that my basic demographics and social history are a part of my Emergency Preparedness information.

I understand that my information will be shared only with persons authorized to respond in an emergency, such as government agencies, law enforcement, or those acting on their behalf.

Client Initial: _____

I consent to the collection and sharing of my information as initialed above. This authorization shall not expire unless revoked by me or my legal representative.

Signature of Individual or Legal Representative

Date

Individual's Name (Print)

Legal Representative's Name (Print)

Power of Attorney (POA)

Guardianship

Please describe the relationship between the legal representative and the client:

FOR OFFICE USE ONLY

ATTESTATION (To be completed by the 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

Worker's Name (Print)

Worker's Title (Print)