# Reporting Concerns regarding Sexual or other forms of Harassment

If you have a concern related to sexual or any form of harassment, you are encouraged to complete this form and submit it to Human Resources management. This form can be mailed through regular mail or interoffice mail to Human Resources management, 60 Academy Rd., Albany, NY 12208; emailed to humanresources@northernrivers.org ; or faxed to 518-426-2891. Once you submit this form, we will follow our Fair Treatment Practices Policy and investigate any concerns. If you are more comfortable reporting verbally or in another manner, we will still follow our Fair Treatment Practices Policy and investigate any concerns. If you have additional questions, please refer to HR 09, Fair Treatment Practices Policy.

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| Employee Information |

Your Name Click here to enter text.

Work Address Click here to enter text.

Work Phone Click here to enter text.

Job Title Click here to enter text.

Email Click here to enter text.

Personal Phone Click here to enter text.

Preferred Communication Method Choose an item.

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| Supervisory Information |

Immediate Supervisor’s Name Click here to enter text.

Immediate Supervisor’s Title Click here to enter text.

Immediate Supervisor’s Work Phone Click here to enter text.

Immediate Supervisor’s Work Address Click here to enter text.

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| Complaint Information |

Your complaint of Sexual or another form of Harassment is made against:

Name Click here to enter text.

Title Click here to enter text.

Work Address Click here to enter text.

Work Phone Click here to enter text.

Relationship to you: Choose an item.

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| Employee Information |

1. Your Name Click here to enter text.
2. Please describe what happened and how it is affecting you and your work. Please us additional sheets of paper if necessary and attach any relevant documents or evidence.
3. Date(s) the incident(s) occurred: Click here to enter text.
4. Is the behavior continuing? Click here to enter text.
5. Please list the name and contact information of any witnesses or individuals who may have information related to your complaint.

Click here to enter text.

Your Name Click here to enter text.

1. Please describe what happened and how it is affecting you and your work. Please us additional sheets of paper if necessary and attach any relevant documents or evidence.

Click here to enter text.

1. Date(s) the incident(s) occurred: Click here to enter text.

Is the behavior continuing? Click here to enter text.

1. Please list the name and contact information of any witnesses or individuals who may have information related to your complaint.

Click here to enter text.

1. (Optional) Have you previously complained or provided information (verbal or written) about related incidents? If yes, when and to whom did you complain or provide information?

If you have retained legal counsel and would like us to work with them, please provide their contact information.

Click here to enter text.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE COMPLETE BOTH SIDES OF THIS DOCUMENT**

Client Name: Date of Birth:

My signature below indicates that I understand the following:

1. I may revoke this authorization in writing at any time, except to the extent Northern Rivers Family of Services has taken action in reliance on this authorization and send to the Privacy Officer at 60 Academy Road, Albany, NY 12208 or the program supervisor.
2. This authorization is voluntary and Northern Rivers Family of Services may not condition treatment or benefits on my willingness to sign this authorization.
3. I have a right to a signed copy of this authorization.
4. Any information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by law ***unless*** this information is related to HIV/AIDS, consists of the records of a federally assisted substance and alcohol abuse program, or consists of records of a New York state–licensed mental health facility,
in which case the information may be redisclosed only in accordance with applicable laws governing such
information or records.
5. If this information relates to HIV/AIDS, I may ask for a list of people who can be given my confidential HIV-related information without a release form. If I experience discrimination because of the release of HIV-related information, I may contact the New York State Division of Human Rights at 888.392.3644 or the New York City Commission on Human Rights at 212.566.5493. These agencies are responsible for protecting my rights.

I have read and fully understand this authorization form. Proof of identity may be required. By signing below, I authorize Northern Rivers Family of Services to use and/or disclose my protected health information of behavioral/mental health consistent with the terms of this authorization.

 *Name of individual or legal guardian (please print) Signature Date*

 Authority to sign: [ ]  Client [ ]  Parent [ ]  Legal guardian

 *Name of individual or legal guardian (please print) Signature Date*

 Authority to sign: [ ]  Client [ ]  Parent [ ]  Legal guardian

 *Name of individual health care provider requesting the information (please print) Date*

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| **If disclosing this type of data, consent and signature from a minor client is required.****Check all that apply:**☐ Mental health (12 years and older – NY Mental Hygiene Law § 33.16)☐ Substance abuse ☐ Reproductive health☐ HIV ☐ Sexual trauma  *Signature of minor client Date* |

**NOTICE TO ACCOMPANY DISCLOSURE OF HIV-RELATED INFORMATION**

This information has been disclosed to you from records protected by State law. State law prohibits you from making any further disclosure of this information without the express written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure of this information.

**NOTICE TO ACCOMPANY DISCLOSURE OF ALCOHOL/DRUG INFORMATION**

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**PLEASE COMPLETE BOTH SIDES OF THIS DOCUMENT**