

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, date of birth _____,

hereby authorize _____

to release my medical information to:

Specific Identification of Person or Entity Authorized to Receive Information

I authorize the following information to be released:

- | | |
|---|---|
| <input type="checkbox"/> Narrative Summary | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> After Care Services Plan | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Psychiatric Examination | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Psychology Evaluation | <input type="checkbox"/> Orders |
| <input type="checkbox"/> Social Work Assessment | |

Dates of Treatment

- Records from other providers (specify or 'all'):
- _____
- _____
- Other (specify):
- _____
- _____
- _____

This authorization includes release of records relating to ("X" appropriate boxes):

- | | |
|---|---|
| <input type="checkbox"/> Diagnoses and/or treatment for alcohol and/or drug abuse | <input type="checkbox"/> HIV test results |
| <input type="checkbox"/> AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment | <input type="checkbox"/> Diagnoses and/or treatment relating to other communicable diseases |

Indicate here any additional exceptions or exclusions, if any, to information released.

This authorization for use/disclosure is for the following purpose:

My refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, or enrollment in a health plan. This authorization will remain effective for **90/180 days (circle one)** unless an earlier date or condition/event is specified here _____ . However, I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that ODMH has already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to:

Name and Address

Signature of Individual/Guardian/Personal Representative	Date Signed	Print Name
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If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here: _____

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by State and Federal law. ORC 5122.31, 42 CFR Part 2, and/or ORC 3701.243 prohibit you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is NOT sufficient for this purpose.

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FOR OFFICE USE ONLY
Staff Person Releasing Information
Date Information Released