



Statement of Conflict of Interest

Directions: This form is for use by any person interested in submitting a statement of Conflict of Interest against an Ohio Certified Peer Recovery Supporter.

- Include copies of any relevant documentation
- Complete and sign the release included.
- Please submit a signed release of information signed by the client so OhioMHAS can access to client files, if applicable.
- Include names, addresses and telephone numbers of any individuals who have knowledge of the situation.

1. Statement Against:

Name: _____

(Certified Ohio Peer Recovery Supporter)

Employer/Name of Practice: _____

Address: _____

Telephone #: _____ Email: _____

Certificate #: (If known) _____

2. Statement Filed By:

Name _____

Address: _____

Telephone #: _____ Fax #: _____

Email: _____

3. Action You Have Taken:

Have you voiced your concern to leadership at your agency? If yes, what was the outcome?

4. List Names, Addresses and Phone numbers of any witnesses who either have knowledge of the conflict of interest or may have other relevant information. Briefly describe the information each individual possesses:



Promoting wellness and recovery

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1. Name: _____
2. Date of Birth: _____
3. I authorize: (Practitioner/Agency Name) _____
To release information to:

Community Recovery Initiatives Administrator
The State of Ohio Department of Mental Health and Addiction Services
30 East Broad Street, 36th Floor
Columbus, OH 43215
Telephone (614) 466-2596 Fax (614) 644-1502

4. Date(s) of service (Month, Day & Year to the best of your knowledge): _____

5. **Specific information to be released** (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> 3rd Party Correspondence |
| <input type="checkbox"/> Psychiatric/Mental Health Evaluations | <input type="checkbox"/> Consent for Treatment |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Custody/Parenting Documentation |
| <input type="checkbox"/> Progress Reports | <input type="checkbox"/> Correspondence with Attorneys/GAL/Courts |
| <input type="checkbox"/> Discharge Plan | <input type="checkbox"/> Other (specify): _____ |

6. Reason for disclosure: _____

7. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon. **This authorization (unless revoked) expires one year from the date provided below.**

Signature: _____ Date: _____
(Patient/Parent/Legal Guardian)

Revocation of Release of Information:

I hereby withdraw my consent for this release of information:

Signature: _____ Date: _____
(Patient/Parent/Legal Guardian)