Name of Provider or Individual Assisting with Completion:	
Date *(mm/dd/yyyy):*	Phone and Email:

Recovery Requires a Community Authorization for Release of Information

I, _____ [_____], hereby authorize the Ohio Department
(Individual's First & Last Name) *(Social Security Number)*
of Mental Health and Addiction Services to release my Protected Health Information (PHI) and other personal, non-public information to the individuals or agencies listed below for the purpose of facilitating my enrollment in the Recovery Requires a Community Program and to assist with my transition from an institution to an integrated community setting. I understand that PHI and other personal, non-public information includes, but may not be limited to, my social security number, date of birth, address, phone number, income type and/or amount, physical or behavioral health diagnoses, and previous or current treatment and services received.

- Ohio Department of Medicaid (ODM)
- Alcohol, Drug Addiction, and Mental Health (ADAMH) or Alcohol and Drug Addiction Services (ADAS) Boards
- Providers contracting with OhioMHAS, ODM, or ADAMH/ADAS Boards

I authorize the following information to be released to providers or agencies involved in my transition and stabilization in the community, as well as for the purpose of the evaluation of the program:

- Medicaid information, including claims data
- Helping Ohioans Move Expanding (HOME) Choice documentation
- Documentation required for Recovery Requires a Community application
- Diagnoses or treatment for alcohol and/or drug abuse
- Diagnoses or treatment relating to other communicable diseases
- Pre-Admission Screening and Resident Review (PASRR) information related to institutional stay

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 365 days unless an earlier date or condition/event is specified here: _____. I understand 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 OhioMHAS has already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to: *Community Transitions c/o OhioMHAS, 30 E. Broad Street, 36th Floor, Columbus, OH, 43215*.

Printed Name of Individual and Legal Guardian (if applicable)	Signature of Individual or Legal Guardian	Date Signed *(mm/dd/yyyy)*

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 5119.27, 5119.28, 5122.31, and/or 42 CFR Part 2 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.

Please return to Community Transitions via email Recovery@mha.ohio.gov or fax 614-488-4504.