Zepf Center

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORD INFORMATION

Revocation only
☐Verbal ☐Written

Internal Use Only
☐File: Do not send information at this time
☐Send documents upon signature of client

Client Name (First, Middle, Last)_____ Date of Birth:_____

Social Security #:_____ Dates of Service to be Released:_____ to_____

RELEASE INFORMATION TO:

I hereby authorize Zepf Center 6605 W. Central Avenue, Toledo, Ohio 43617 to:
☐obtain from or ☐release to or ☐share/disclose with

Check only one:

☐Columbia Gas
☐Department of Jobs and Family Services (DJFS)
☐Family Services of NW Ohio
☐Flower Hospital
☐Harbor
☐Juvenile Detention_____
☐Lucas County Board of DD
☐Lucas County Children's Services
☐Lucas County Court System
☐Lucas County Sheriff's Office
☐Lucas Metropolitan Housing (LMHA)
☐Lutheran Social Services
☐Neighborhood Health Association (NHA)
☐Neighborhood Properties Inc. (NPI)
☐Rescue Mental Health Services
☐St. Charles Hospital
☐St. Luke's Hospital
☐St. Paul's Community Center
☐St. Vincent Medical Center
☐Social Security Administration
☐Sylvania Municipal Courts
☐Toledo Edison
☐Toledo Hospital
☐Toledo Municipal Courts
☐Toledo Public Schools (TPS)
☐Sylvania Municipal Courts
☐Unison Behavioral Health Group
☐Washington Local Schools
☐Probation/Parole Officer:_____
☐Primary Care Physician:_____
☐Other:_____
(Include Complete Name of Person/Entity and address including City, State and Zip Code)

INFORMATION TO BE RELEASED & PURPOSE:

By signing this form, I voluntarily authorize access, use and disclosure of my: (initial each of the following you authorize)

_____Mental health diagnosis and treatment information
_____HIV/AIDS/ARC Testing and/or Status
_____Alcohol & other drug diagnosis and treatment information
_____Genetic Testing

Check the following information to be released (check all that apply):

☐Entire medical record (does not include HIV/AIDS/ARC Testing and/or Status, Genetic Testing or Alcohol and Other Drug diagnosis and/or treatment information unless initialed above.) OR

☐Diagnostic Assessment ☐Current Treatment/Service Plans ☐Medical Progress Notes ☐Psychiatric Diagnostic Evaluations
☐Medications ☐Urine Screens/Lab Results ☐AOD Progress Notes ☐CPST/Case Management Notes
☐Attendance Records ☐Discharge Summary ☐Diagnosis ☐Written Letter / Correspondence
☐Therapy Summary ☐Billing Information ☐Other: (specify)_____

Purpose: The information shared will be used: (check all that apply)

☐To help with my treatment and care coordination
☐To help pay for treatment
☐Legal
☐To assist the provider or organization to improve the way they conduct work
☐To help me apply for benefits or assistance with utilities or housing
☐Other (specify)_____

EXPIRATION OF DISCLOSURE:

This authorization for the release/obtaining of information will automatically expire in six months (180 days) after the date of authorization unless I expect to continue receiving services beyond the 180 days and extend the authorization to a maximum of one year (365 days) after the date of authorization as indicated below:

Expiration date:_____ Condition date or event of earlier / later expiration:_____

- I understand that the information disclosed is protected by law and may not be redisclosed without my written authorization or as otherwise authorized by law. However, I understand that Zepf Center cannot control the recipient's use of the information.
- I understand that authorizing the use of disclosure of the above information is voluntary and Zepf Center will not condition treatment, payment, enrollment, or eligibility for benefits on the execution of this Authorization.
- I understand that this authorization can be revoked by me or my authorized agent at any time, except to the extent that action has been taken by Zepf Center in reliance on the authorization and that the revocation must be in writing and signed and dated by me or my authorized agent (upon revocation of consent, further release of information shall ceases immediately. A verbal revocation may serve until a written revocation can be obtained by calling Zepf Center: 419-841-7701 and speaking with a Release Clerk.
- For more information about your privacy rights, please refer to Zepf Center's HIPAA Notice of Privacy Practices and 42 CFR Part 2 Summary Sheet.

_____ _____
Signature of Client or Legally Authorized Representative Date

_____ _____
Relationship of Authorized Agent (if different than Client) Name of staff member facilitation this response

CONFIDENTIALITY STATEMENT: This information has been "disclosed to you from records protected by Federal confidentiality laws. 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 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client."

I hereby revoke my consent for release of information above:_____
Signature of Client or Legally Authorized Representative Date

Staff Member Facilitating Revocation (written or verbal) _____ Effective Date:_____