Release of Information v4

Client:
Actual Date:
Name of Recipient:
Agency Staff:

:

Authorization to Release and/or Exchange Information

Client **Date of Birth**

Client Social Security Number (last four digits)

Client Phone Number

I, the undersigned, hereby authorize OhioGuidestone and its subsidiary organizations, including A Renewed Mind (collectively "The Agency") to use or disclose my personal health information and/or confidential information as described below to:
Name of Recipient

Recipient Phone

Recipient Fax

Recipient Address (Street)

Recipient City, State Zip

I further authorize the EXCHANGE of information and for the party identified as Recipient above to also disclose my personal health information and/or confidential information to the Agency.

☐ Yes
☐ No

Type of Information to be Released/Exchanged:

☐ Mental Health Assessments/Evaluations ☐ Treatment Plan/ITP/Treatment Updates ☐ Progress Notes ☐ General Medical Records (except HIV/AIDS related diagnosis and treatment) ☐ Partial Hospitalization Records ☐ HIV/AIDS Related Diagnosis ☐ Court Reports ☐ Employment Records ☐ School Reports/Records/IEP/MFE ☐ Discharge Summary ☐ Alcohol/Drug Assessment (LOC) ☐ Alcohol/Drug Treatment Summary ☐ Alcohol/Drug Treatment Plan ☐ Alcohol/Drug Progress Notes ☐ Alcohol/Drug Discharge Plan ☐ Urinalysis/Breathalyzer Results ☐ Other

If Other selected, specify:

A date range for the time period to be released should be completed when records are requested or when only limited information is to be released. If no dates are entered, no time frame limitation will be applied.

Date of Service to Release (FROM):

Date of Service to Release (TO):

Purpose for Disclosure: (REQUIRED)
(purpose for disclosure must be completed prior to processing, e.g., continuity of care, personal use, legal)

I understand and acknowledge that the requested information may contain information regarding physical and mental illness, HIV test results or diagnosis, AIDS or AIDS related conditions, alcohol and/or drug dependence/abuse*. I also understand that information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and may no longer be protected.

I understand that I may see and copy the information described on this form if requested in writing. I also understand that the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. The health care providers listed above will not receive financial or in-kind compensation in exchange for using or disclosing my health care information.

I understand I have a right to revoke this authorization (in writing) at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

If not revoked, *this authorization will expire one year from the date of signature* or on the following date, event or condition (if earlier) :

Event of condition for revocation

I understand there may be charges for the copying and release of information and accept financial responsibility for those charges. I understand and agree that a copy of this authorization shall have the same force and effect as the original.

Client Signature:

Printed Name:

Date:

Parent/Legal Guardian/Representative**:

Printed Name:

Date:

**Prohibition Against Re-Disclosure

This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit 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 and alcohol or drug abuse client.

** *If other than client signature, a copy of legal paperwork verifying the client personal representative **MUST** accompany the request unless otherwise on file with provider (e.g., court appointed guardian, durable power of attorney for healthcare, grandparent power of attorney). Exception: Parent signing for client under the age of eighteen and the County agency holding custody.*

Revocation of Authorization Release of Information

At the date and time noted below, I hereby revoke permission for The Agency to further release information to the above-noted recipient, except to the extent the program has already acted in reliance upon it.

Client/Parent/Legal Guardian/Representative:

Revocation Date:

Rev 816: