Zepf Center
Authorization for Disclosure/Consent to Release/Obtain Information

Agency Use Only
Chart Number:__________________
Staff Name for Attestation: __________________
☐ For File ☐ Records to be Sent

Client Name: ____

Date of Birth: ____/____/______ Last four digits of Social Security# ______

In accordance with Federal Regulations 42 CFR part 2 and HIPAA, I hereby authorize:

Zepf Center, 6005 W. Central, Toledo, Ohio 43617

☐ to Release To: and/or ☐ Obtain From:

Name of individual, institution: ____

Address (city/state/zip): ____

Phone: ________________________ Fax: ________________________

Purpose of Disclosure: (Check one or more):
☐ Comprehensive Treatment ☐ Family Involvement ☐ Aftercare/follow-up ☐ Legal Issues ☐ Continuity of Care
☐ Advocacy with Benefits/Assistance ☐ Other: ________________________

Expiration of Release:(Choose one only)
If no option is specified below, this authorization will expire in one year.

☐ 1 Year ☐ Time period of ________________ to __________ (**Dates Only**)

Information Hereby Authorized to Be Released

☐ Medical Progress Notes
☐ Attendance
☐ Discharge Summary/Plan
☐ Letters
☐ Psychological Testing
☐ Other (specify)

☐ Clinical Progress Notes
☐ Diagnosis
☐ Assessments
☐ Treatment Plan
☐ Lab Results

☐ Drug Screen Results
☐ SUD Progress Notes
☐ SUD Medical Notes
☐ Billing/Insurance Information
☐ Medications

Other: ____

For the Time Period of:(Choose one only)

☐ Most Recent Admission ☐ All Admissions ☐ Time period of __________ to __________ **(Dates Required)**

Including psychiatric records related to emotional illness, and information regulated by federal public law 930-282, Confidentiality of Alcohol and Drug Abuse Patients. Also included are records documenting the diagnosis and/or treatment of AIDS, ARC, HIV Positive and other related diseases.

Re-Disclosure:
The confidentiality of the information being disclosed is protected by State and Federal law. ORC 5122.31, ORC 3701.243 and 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, his/her authorized representative, or as otherwise permitted by law. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). 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 CFR 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.

Terms:
I understand I can refuse to sign this authorization. Refusal to sign this document shall not alter treatment, payment, enrollment or eligibility for benefits at Zepf Center. I understand that the information disclosed is protected by law and should not be re-disclosed 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, and I hereby release Zepf Center from any liability for the recipient's re-disclosure of such information. I understand that this authorization may be revoked by me at any time, except to the extent the program or person who is to make the disclosure has already acted in reliance on it. The revocation must be signed and dated by me. Upon revocation of consent, further release of information shall cease immediately.

____ ________________
Signature of Client/Guardian*/Authorized Representative*and authority to act on client's behalf **Date**

***If other than the client, relationship to the client is:** ☐ Parent ☐ Guardian ☐ Other: ________________

Revocation:
Upon revocation of consent, further release of information shall cease immediately. I hereby revoke my consent for the release of the above information.

____ ________________
Signature of Client/Guardian*/Authorized Representative* and authority to act on client's behalf **Date**
***If other than the client, relationship to the client is:** ☐ Parent ☐ Guardian ☐ Other: ________________