OhioGuidestone
WHERE NEW PATHS BEGIN

# Authorization to Release and/or Exchange Information

Client's Name (Last, First) _____ Date of Birth _____

Social Security Number (last four digits) _____ Phone Number _____

**I, the undersigned, hereby authorize OhioGuidestone to use or disclose my personal health information and/or confidential information as described below to:**

Name of Recipient _____ Phone _____ Fax _____

Address (Street) _____ (City) _____ (State) _____ (Zip) _____

☐ If marked, 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 OhioGuidestone.

## 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)
☐ Other (specify): _____
☐ Partial Hospitalization Records
☐ HIV/AIDS Related Diagnosis
☐ Court Reports
☐ Employment Records
☐ School Reports/Records/IEPIMFE
☐ 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

## Dates of Service to Release (FROM): _____ (TO): _____

## Purpose for Disclosure: _____

(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 written below** or on the following date, event or condition (if earlier): _____.

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.

Signature of Client _____ Printed Name _____ Date _____

Signature of Parent/Legal Guardian/ Personal Representative** _____ Printed Name _____ Date _____

**Prohibition Against Re-Disclosure: 42 CFR part 2 prohibits unauthorized disclosure of these records. This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. **If other than client's signature, a copy of legal paperwork verifying the client's 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 for Release of Information

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

Client/Parent/Legal Guardian/Personal Representative** _____ Date/Time _____