Authorization to Release Information (Standard/ TPO)

OhioGuidestone
WHERE NEW PATHS BEGIN

Client/Patient Name (Last, First) Date of Birth

Social Security Number (last four digits) Phone Number

SUD Patient/clients: Patients/clients receiving substance use disorder (SUD) services may provide a single consent for all future uses and disclosures of SUD records and information for purposes of treatment, payment, or healthcare operations (TPO) in accordance with 42 CFR Part 2. Please note that if you provide a single consent for treatment, payment, and healthcare operations, records disclosed to a covered entity or business associate under this consent may be redisclosed by the covered entity or business associate, to the extent allowed under HIPAA.

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

For SUD clients/patients ONLY: For single consent for all future uses and disclosures of SUD records and information for purposes of treatment, payment, and health care operations:

☐ All treating providers, health plans, third party payers, intermediaries, and people helping to operate this program.

For MH, SUD, and Primary Care clients/patients:

Recipient name and/or Recipient Group: _____

_____

If the recipient is a covered entity or business associate to whom a record is disclosed for purposes of treatment, payment, or health care operations, the patient's record (or information contained in the record) may be redisclosed in accordance with the permissions contained in HIPAA regulations. This consent does not permit use or redisclosure for civil, criminal, administrative, or legislative proceedings against you. Intermediaries include health information exchanges such as CliniSync that enable your healthcare providers to securely access your health records for a better picture of your healthcare needs.

Recipient Contact information: (Phone)_____(Fax)_____

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

☐ If marked, I further authorize the **EXCHANGE** of information and for the party or parties identified as the Recipients above to also disclose my personal health information and/or confidential information to the Agency.

Type of Information to be Released/Exchanged:

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

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

Purpose for Disclosure: ☐ Treatment, payment, and/or healthcare operations ☐ Continuity of Care ☐ Personal Use ☐ Legal ☐ Other_____

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. *Optional:* if you would like this authorization to expire sooner than one year from the date of signature, specify the expiration date, event, or condition (if earlier):_____

Signature of Client/Patient **Printed Name** **Date**

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

42 CFR Part 2 prohibits unauthorized use or disclosure of these records. *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 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/Personal Representative:_____Date_____