**Concord Counseling Services**

**Authorization to Release/Exchange Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize Concord Counseling Services
 (Name of person authorized to give consent)

to release and exchange medical information regarding \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
 (Name of client) (Date of birth)

Information can be released to and exchanged with Westerville City Schools.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Address and/or fax number of organization where information should be sent)

**Dates of Treatment**:

I authorize the following information to be released:

x□Narrative Summary x□Diagnostic Assessment x□Lab Results x□School/Employment Records

x□Psychiatric Evaluation x□Progress Notes x□Court Records x□ Medical Orders/Records

x□Treatment Plan x□Discharge Summary □Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Indicate any exceptions to the information being released**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Amount of information to be disclosed**:

□Past 3 months x□Covering most recent admission □Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of disclosure of information**:

x□Continuity of care □ Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization will remain effective for 90/180 days **(circle one)** unless an earlier date or condition/event is specified here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Or**: x□ This authorization will expire upon completion of treatment.

My refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, or enrollment in a health plan.

I understand I have the right to shorten the authorization period. I understand that I have the right to revoke this authorization at any time in writing, and that the revocation will be effective except to the extent that Concord has already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to:

Concord Counseling Services, 700 Brooksedge Blvd. Westerville, OH 43081

 Fax: 882-3401

Attn: Medical Records Coordinator

|  |  |  |
| --- | --- | --- |
| Signature of Client/Guardian/Personal Rep | Date Signed | Printed Name |

|  |  |  |
| --- | --- | --- |
| Witness | Date Signed | Printed Name |

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Note: This information has been disclosed to you from records whose confidentiality is protected from disclosure by State and Federal law. ORC 5122.31, 45 CFR Part 2, and/or ORC 3701.243 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. Drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 CFR Parts 160 and 164. These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.

**For Office Use Only**

Staff Releasing Information Date Released

**Revocation of Authorization for Release of Information**

I hereby revoke my permission for use or disclosure of m y protected health information to the party specified above. Further release of information shall cease immediately.­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­

|  |  |  |
| --- | --- | --- |
| **Signature of Client/legal Representative** | **Date Signed** | **Signature of Staff Witness** |