

**AUTHORIZATION FOR THE RELEASE OF INFORMATION**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

The following **agency/program/provider(s)/supervisor** are authorized to  disclose,  receive or  exchange information

List Agency/Program/Provider(s)/Supervisor \_\_\_\_\_

Address \_\_\_\_\_

Phone/Fax \_\_\_\_\_

**Authorized Organization/Individual to Whom Disclosure is made:** Ravenwood Health

List: Ravenwood Program/Provider(s) and Supervisor: \_\_\_\_\_

**Purpose of Disclosure: (check all those that apply)**

- |  |  |
|--|--|
| <input type="checkbox"/> Coordinate treatment  | <input type="checkbox"/> To gather information for ongoing treatment |
| <input type="checkbox"/> Gather assessment information for treatment planning                              | <input type="checkbox"/> Provide clinical recommendations            |
| <input type="checkbox"/> Copy records and release them to authorized agency/program/provider(s)/supervisor |  |
| <input type="checkbox"/> Other purposes (specify): _____   |  |

**Effective Dates of Authorization:** \_\_\_\_\_

**Type of information to be disclosed:**

|  |   |  |
|--|---|--|
| <input type="checkbox"/> Psychiatric Assessment                    | <input type="checkbox"/> Sexual Aggression Assessment | <input type="checkbox"/> Medications Prescribed                      |
| <input type="checkbox"/> Clinical Assessment Information           | <input type="checkbox"/> Attendance in treatment      | <input type="checkbox"/> Lab reports (including drug screen results) |
| <input type="checkbox"/> Diagnosis                                 | <input type="checkbox"/> Progress Notes               | <input type="checkbox"/> Progress in treatment                       |
| <input type="checkbox"/> Assessment Summary                        | <input type="checkbox"/> Financial Needs              | <input type="checkbox"/> Educational Testing/Records                 |
| <input type="checkbox"/> Drug & Alcohol Assessment                 | <input type="checkbox"/> Court Testimony & Records    | <input type="checkbox"/> Crisis Interventions                        |
| <input type="checkbox"/> Drug & Alcohol Family Information         | <input type="checkbox"/> Medical History              | <input type="checkbox"/> Discharge Summary/Plan                      |
| <input type="checkbox"/> Psychological Testing                     | <input type="checkbox"/> Hospitalization Records      | <input type="checkbox"/> Risk Assessment                             |
| <input type="checkbox"/> Treatment Recommendations (including AoD) | <input type="checkbox"/> Other--specify               | <input type="checkbox"/> HIV/Aids Related Diagnosis/Treatment        |

**Amount of information to be disclosed:**

Information on most recent admission  Other amount of information (Specify) \_\_\_\_\_

**Approved method for sending records and communicating information:**

- |                                  |                                    |
|----------------------------------|------------------------------------|
| <input type="checkbox"/> Fax     | <input type="checkbox"/> Telephone |
| <input type="checkbox"/> Pick up | <input type="checkbox"/> Mail      |

\_\_\_\_\_  
 Client Signature and Date

\_\_\_\_\_  
 Parent and/or Guardian Signature and Date

**Revocation:** This authorization is subject to writing revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it.

I hereby **revoke** consent in writing: \_\_\_\_\_  
 Client Signature and Date

\_\_\_\_\_  
 Witness Signature and Date

**Prohibition Against Re-Disclosure:** 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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see 42 CFR 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 42 CFR 2.12(c)(5) and 42 CFR 2.65.

**RAVENWOOD HEALTH**

12557 Ravenwood Drive; Chardon, Ohio 44024

440-285-3568 FAX 440-285-4552

This authorization, unless revoked earlier, expires on my formal termination from treatment at Ravenwood Health **not to exceed 180 days** after signing the release, whichever occurs first. I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

**SUD Disclosure Statement:**

Statement of Understanding: I (or other individual authorized to sign in lieu) confirm my understanding that, upon my request, I must be provided a list of entities to which information has been disclosed pursuant to the general designation.

I understand and acknowledge that the requested health information may contain information regarding physical and mental illness; HIV testing results or diagnosis; treatment of AIDS/AIDS-related conditions; and/or alcohol or drug abuse, all of which are protected under federal or state confidentiality regulations (42 CFR Part 2, 45 CFR Part 160 and 164, O.R.C. 3701.243, etc.) and these records cannot be re-disclosed without my written consent unless permitted by the regulations. I also understand that my mental health treatment records are protected by HIPAA but that if the recipient of my information is not subject to HIPAA, it may no longer be protected by state or federal law and therefore subject to re-disclosure to a third party

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