RAVENWOOD HEALTH
12557 Ravenwood Drive; Chardon, Ohio 44024
440-285-3568 FAX 440-285-4552

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 to Whom Disclosure/Receipt/Exchange is made: Ravenwood Health

_____

Purpose of Disclosure: (check all those that apply)

☐ Coordinate treatment
☐ To gather information for ongoing treatment
☐ Gather assessment information for treatment planning
☐ Provide clinical recommendations
☐ Copy records and release them to authorized agency/program/provider(s)/supervisor
☐ Other purposes (specify):_____

Effective Dates of Authorization:

☐ Release of Information will expire upon termination of treatment with Ravenwood Health.
☐ Release of Information will expire on _____,

Type of information to be disclosed:

☐ Psychiatric Assessment
☐ Clinical Assessment Information
☐ Diagnosis
☐ Assessment Summary
☐ Drug & Alcohol Assessment
☐ Drug & Alcohol Family Information
☐ Psychological Testing
☐ Treatment Recommendations (including AoD)
☐ Safety Assessment
☐ Sexual Aggression Assessment
☐ Attendance in treatment
☐ Progress Notes
☐ Financial Needs
☐ Court Testimony & Records
☐ Medical History
☐ Hospitalization Records
☐ Medications Prescribed
☐ Medications Prescribed
☐ Lab reports (including drug screen results)
☐ Progress in treatment
☐ Educational Testing/Records
☐ Crisis Interventions
☐ Discharge Summary/Plan
☐ HCR-20 Violence Risk Assessment
☐ 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:

☐ Fax
☐ Pick up
☐ Telephone
☐ Mail
☐ Secure Email

_____ _____
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.

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This authorization, unless revoked earlier, expires on my formal termination from treatment at Ravenwood Health unless otherwise stated. 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 CRF 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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