1173 N Ridge Rd East • Lorain OH 44055
440.233.2020 Tel • 440.233.2030 Fax

AUTHORIZATION FOR RELEASE OF INFORMATION

RELEASE OF INFORMATION MUST BE 2-SIDED

The Lorain County Board of Mental Health is hereby granted my permission to

Release ( ) and/or obtain from ( ):

(Full name and address of person, institution or agency)

Such information as may be necessary regarding the treatment of:

_____ _____ _____
(Print or type Client's Full Name) Date of Birth Social Security Number

A COPY MAY BE ACCEPTED AS A SUBSTITUTE FOR AN ORIGINAL FORM

Purpose or need for disclosure: _____

_____

I authorize the release of the specific information for which I have circled and initialed below only if it is necessary to secure or coordinate needed services identified in my case plan by the persons/programs/ agencies identified above:

Circle yes and initial

yes _____Identifying information: name, birth date, sex, race, address and telephone number.

yes _____Social Security Number

yes _____General Medical: medical records (except for HIV, AIDS and drug and alcohol treatment records) disability, type of services being received and name of agency providing services to the individual named above.

yes _____ Social History: social history, treatment/service history and other personal information regarding the individual named above.

yes _____ Mental Health: Diagnostic Assessment, treatment plans, transfer/discharge summaries, psychological assessments, psychiatric evaluations, treatment summaries, lab results and medication histories.

yes _____ HIV and AIDS related diagnosis and treatment.

yes _____Current substance abuse treatment, recommendations and involvement specifically,

_____

yes _____ Financial Information necessary to establish eligibility for public assistance including but not limited to pay stubs, W2's and tax returns, and other financial information.

yes _____ Legal history, current and pending legal information

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If not previously revoked, this consent expires on the _____day of_____, 20_____.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness/Agency Representative Date

I understand that my alcohol and drug abuse patient records are protected under the Federal regulations governing confidentiality of those records, (42 CFR Part 2), cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand this Release expires 180 days from the date it is signed unless otherwise indicated by me. I also understand that I may cancel this Release at any time in writing with my signature, and the date it is signed, and delivering it to **the Lorain County Board of Mental Health**. Canceling it applies to that day forward and not to information already shared.

Violation of Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

TO ALL AGENCIES SENDING AND/OR RECEIVING INFORMATION DISCLOSED AS A RESULT OF THIS SIGNED CONSENT:

1. If the records released include information of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:

PROHIBITION ON REDISCLOSURE OF INFORMATION
CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT

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 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.

2. If the records released include information of an HIV-related diagnosis or test results, the following statement applies:

This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for the purpose of the release of HIV test results or diagnoses.

3. The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release of it is prohibited unless the further disclosure is expressly permitted by the person to whom it pertains, Juvenile Court/DYS in the case of youth records, or applicable federal and/or state law.

Revised 7/03
Updated 11/05