FOUNDATIONS
Behavioral Health Services

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____ **Date of Birth:** _____

I hereby authorize Foundations Behavioral Health Services to ☐ provide ☐ receive ☐ exchange confidential information to/from/with the following person or entity:

_____
(name of person/entity receiving/exchanging information)

TYPE OF INFORMATION TO BE DISCLOSED:

☐ Progress Notes	☐ Progress in Treatment	☐ Diagnostic Assessment Information
☐ Lab Results	☐ Medical Tests	☐ Medical/Medication Records
☐ Attendance	☐ Treatment Plan	☐ Treatment Recommendations
☐ Drug Testing	☐ Pregnancy Testing	☐ Prenatal Care
☐ HIV/AIDS Testing or Status	☐ Psychological Evaluation	☐ Psychiatric Evaluation
☐ Diagnosis	☐ Discharge Summary/Prognosis	☐ Entire Case Record

☐ Other (specify): _____

PURPOSE OF DISCLOSURE:

☐ To coordinate treatment
☐ To gather assessment information for treatment planning
☐ To gather information for ongoing treatment
☐ Other (specify): _____

AMOUNT OF INFORMATION TO BE DISCLOSED:

☐ Information covering the previous three months
☐ Information covering the most recent admission
☐ Other (specify): _____

I understand that this authorization is voluntary and that I may refuse to sign this authorization.

I understand that, except to the extent that action has already been taken on my authorization, I may revoke, lengthen, or shorten the period of this authorization at any time by providing written notification to the agency.

I have read and I understand the conditions specified on the back of this form.

I understand that I may inspect and/or receive a copy of the information to be released and that I will receive a copy of this authorization form after I sign it.

This authorization shall remain in effect until the specific date or specific event specified:

☐ **Expiration Date:** _____ ☐ **Specific Event:** _____

_____ _____
Signature of Client or Legal Representative Date

_____
Authority/Relationship of the Legal Representative

_____ _____
Signature of Staff or Witness Date

Conditions

The information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations once it is released.

Treatment, payment for services, enrollment or eligibility for benefits cannot be conditioned upon authorization for disclosure of information for any purpose.

Information received by this agency from another entity may be further released or disclosed by this agency, with your specific written authorization.

REVOCATION OF AUTHORIZATION

I, _____ hereby revoke my permission for use or disclosure of my protected health information to the party/parties named on the front of this form. Further release of information shall cease immediately.

_____ _____

Signature of Client or Legal Representative Date

_____

Authority/Relationship of the Legal Representative

_____ _____

Signature of Staff or Witness Date

NOTICE OF DISCLOSURE TO RECIPIENT
IF YOU RECEIVE ALCOHOL OR DRUG ABUSE INFORMATION RELEASED WITH THIS AUTHORIZATION, THE FOLLOWING MAY APPLY TO YOU:

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR, Part 2). Federal law prohibits you from making any further disclosure of alcohol or drug abuse information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR, Part 2 and applicable Ohio law. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 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.)

The information is being disclosed to you pursuant to the written authorization of the person who is subject of the information (or, as appropriate, the person's parent, legal guardian, or other lawfully authorized person representative) or you are receiving this information because the disclosure is required by law.