Authorization to Release Medical Information

❑ **To Family Health**
5735 Meeker Road Greenville, OH 45331
(937)548-9680 Fax# (937)548-2087

❑ **From Family Health** (Address Above)

Physician/Practice/Organization Authorized to Use or Disclose Information

_____
Name of physician/practice/organization

_____
Address

_____
City/State/Zip Phone #: Fax #:

Patient Information

_____
Name of Patient (Print or Type)

_____
Street State City Zip

_____
DOB SS#

Phone Number (_____) _____

Information to be Used or Disclosed:

The information covered by this authorization includes

- ❑ All records
- ❑ Progress Notes
- ❑ Laboratory Reports
- ❑ Radiology Reports
- ❑ Operative Reports
- ❑ Other_____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information related to:

- ❑ Substance abuse (including alcohol or drug abuse)
- ❑ Therapy Notes
- ❑ HIV related information (including AIDS related testing)

X_____ _____
Signature of Patient or Legal Guardian Date

THIS INFORMATION IS TO BE USED FOR THE PURPOSE OF:

- ❑ Permanently transferring all records to another provider
- ❑ For Referral Only
- ❑ Workers' Compensation
- ❑ Second Opinion
- ❑ Legal
- ❑ Insurance
- ❑ Patient's Request
- ❑ Continuity of Care
- ❑ Probation
- ❑ Behavioral Health And Wellness School Based Counseling
- ❑ Other_____

This authorization is effective for one year __/___/____ or specific date less than 1-year __/__/_____ unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Family Health.

Potential for Re-Disclosure

The person or organization to which it is sent may disclose information that is disclosed under this authorization again. It may not be possible to ensure your right to the protection of the privacy of this information once Family Health discloses it to another party. The potential for re-disclosure does not apply to information related to alcohol abuse or drug abuse diagnosis and/or treatment.

Rights of the Individual

- You may inspect or copy the information used or disclosed under this authorization.
- You may refuse to sign this authorization.

_____ _____ _____ _____
Signature of Patient or Patient Representative: **Date:** **Witness:** **Date:**

Relationship to patient (Print Name/Relationship): _____

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 § 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 §§2.12(c)(5) and 2.65. You are not protected under this rule if you are involved in a crime on the premises of the part 2 program or against personnel of the part 2 program, or if reports of suspected child abuse and neglect are made to appropriate state or local authorities.