Community Health Services
Your Partners for Better Health

AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION: **BEHAVIORAL HEALTH**

PATIENT INFORMATION:

Patient Name: ____
Last First MI Maiden or Other

______________________ ______________________ ______________________
DOB SSN Telephone Number

______________________ ______________________ ______________________
Address City/State Zip Code

INFORMATION RELEASED FROM:

____
Name

____
Address

____
City/State/Zip

____
Phone # FAX #

INFORMATION RELEASED TO:

____
Name

____
Address

____
City/State/Zip

____
Phone # FAX #

INFORMATION TO BE RELEASED OR INSPECTED: (Check all applicable categories.)

From ____________________ **to** ______________________ **If no dates listed, we will send only 1 year of information.**
(Date) (Date)

Please check the portion(s) of your Behavioral Health record you authorize to be released:

___ Behavioral Health Office Notes
___ Pharmacy/Prescription/Medication Listing
___ Diagnosis/Problem List
___ Substance Abuse Treatment
___ Psychotherapy Notes (Confidential)
___ Appointment Information
___ Billing and Patient Account Records
___ Other: ____

NOTE: For patients transferring medical care to another provider, you will also be required to transfer your Behavioral Health provider (if applicable). Also, if transferring your medical care to another provider all future appointments will be cancelled.

REASON FOR DISCLOSURE: □ **Transfer of provider** □ **General Sharing of Information** □ **Other** ____________

This authorization will remain in effect for one (1) year or until ________________ and will be effective for medical records generated up to the date of the signature. I understand that:

1. I may revoke this authorization in writing at any time by notifying the Privacy Officer at 410 Birchard Avenue, Fremont, Ohio 43420. I also understand that this authorization will cease to be effective on the date notified except to the extent that information has already been released in response to this authorization.
2. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and the disclosed information is no longer protected by the privacy regulations of the practice.
3. My treatment, payment or eligibility for benefits or enrollment in a health plan may not be conditioned on obtaining this authorization.
4. My refusal to sign this authorization will not jeopardize my right to obtain present or future treatment except where disclosure of the information is necessary for the treatment.
5. I may inspect and receive a copy of the disclosed information upon payment of a reasonable fee as established by state or federal guidelines.
6. I am entitled to a copy of this authorization after I have signed it. This copy will be made available to you upon request. A FAX copy/photocopy of this authorization shall be considered as valid as the original.

______________________________ ______________________________
Signature of Patient Signature of Parent/Guardian/Authorized Person

______________________________ ______________________________
Date Date

Reason Patient Unable to Sign: ___Minor ___Incompetent ___Deceased

For Office Use Only: (please date and initial)

Put on Disk ________ Mailed ________ Faxed ________ Printed & Given ________ Picked Up ________ PHI Request Complete ________

Mailing Address: 410 Birchard Avenue, Fremont, OH 43420 * Phone: 419-334-3869 * Fax: 419-334-8546