CHS Community Health Services
Your Partners for Better Health

AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION: BEHAVIORAL HEALTH

NOTE: Behavioral Health records will be released at the discretion of our Behavioral Health Providers.

PATIENT INFORMATION

PATIENT NAME | MAIDEN OR OTHER

DATE OF BIRTH | SOCIAL SECURITY NUMBER | PHONE NUMBER

ADDRESS – CITY, STATE & ZIP

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 2 years 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: If transferring your medical care to another provider all future appointments will be cancelled.

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REASON FOR DISCLOSURE

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 2221 Hayes 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.

PATIENT SIGNATURE DATE

SIGNATURE OF PARENT/GUARDIAN/AUTHORIZED PERSON DATE

Reason Patient Unable to Sign: ☐ Minor ☐ Incompetent ☐ Deceased

Mailing Address: 2221 Hayes Avenue, Fremont, OH 43420
Phone: 419-334-3869 Fax: 419-334-8546

For Office Use Only (please date and initial)

_____ Put on disk _____ Mailed _____ Faxed

_____ Printed & Given _____ Picked Up _____ PHI Request Complete