

Authorization for Release of Confidential Information

FROM THE RECORDS OF:

Client Name _____ Date of Birth _____
 (Please Print) Last First M/I

This release authorizes: Hopewell staff to: [] receive from, [] disclose to:

(Name of Organization/Person & Relationship) _____ City _____ State _____ Zip Code _____
 Phone # _____ Fax # _____

Please provide information in the format checked: [] Verbal [] Written [] Verbal and/or Written

Description of Information to be released:

- | | | |
|---|---|---|
| <input type="checkbox"/> Diagnostic Assessment & Update | <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Information Shared During Staffing |
| <input type="checkbox"/> Psychiatric Examinations | <input type="checkbox"/> Orders | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Psychological Evaluations | <input type="checkbox"/> Consultations | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Nursing Assessment | <input type="checkbox"/> Quarterly Report | <input type="checkbox"/> Discharge Summaries |
| <input type="checkbox"/> Health History & Physical | <input type="checkbox"/> Drug Screens/Treatment | <input type="checkbox"/> Other (specify) _____ |

Purpose of disclosure is to: [] Assess for Possible Admission [] Continuity of Care [] Updates on Progress [] Other _____

I understand that I, and/or my guardian, if appropriate, may shorten or lengthen the authorization period or may revoke this authorization at any time, except to the extent that action has been taken in reliance on it. If not previously shortened, lengthened or revoked, this authorization is valid for the duration of treatment and residence at Hopewell.

I understand that the information disclosed is protected by law and may not be re-disclosed without my written authorization or as otherwise authorized by law; however, I understand that Hopewell cannot control the recipient's use of the information.

I understand that my treatment, payment for my services, my enrollment or eligibility for benefits cannot be conditioned upon my giving authorization for disclosure of information.

I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse (42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV)/acquired Immune Deficiency Syndrome (AIDS) test results or diagnosis (ORC3701.24.3). I understand that the information disclosed is protected by law and may not be redisclosed without my written consent or as otherwise authorized by law; however I understand that Hopewell cannot control the recipient's use of the information. Records obtained from other sources and made available to Hopewell may not be redisclosed to other parties.

_____	_____	_____
Signature of Individual		Date
_____	_____	_____
Signature of Guardian/Personal Representative	Relationship to Patient/Resident	Date
_____	_____	_____
Signature of Hopewell staff facilitating disclosure of information		Date

TO BE SIGNED ONLY IF AUTHORIZATION IS REVOKED

This authorization can be revoked at any time by providing written notice to Hopewell. I understand that any information released prior to revocation cannot be retrieved and that Hopewell will not be held responsible for such. I hereby release Hopewell from all legal responsibilities or liability that may arise from this act.

SIGNATURE OF INDIVIDUAL/GUARDIAN: _____ DATE: _____

WITNESS: _____ TIME: _____ DATE: _____