

Netcare Corporation Columbus, OH 43223
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name _____ **Date of Birth** _____ **Last four digits of Social Security No.** _____

I hereby authorize: Netcare **Other Treatment Provider (specify):** _____

Other Non-Treatment Provider (specify individual name AND organization, if applicable): _____

Include Name(s), address(es), phone/fax number(s), and/or email address(es) in the spaces provided above

To release to: Netcare **Other Treatment Provider (specify):** _____

Other Non-Treatment Provider (specify individual name AND organization, if applicable): _____

Include Name(s), address(es), phone/fax number(s), and/or email address(es) in the spaces provided above

The specific type of information to be disclosed is (check as many as apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Collateral information | <input type="checkbox"/> Current medication list | <input type="checkbox"/> Nursing Assessment/Triage |
| <input type="checkbox"/> Treatment Progress | <input type="checkbox"/> Most recent psych note/psych discharge | <input type="checkbox"/> Psychological Report |
| <input type="checkbox"/> MH/AOD Assessment | <input type="checkbox"/> Psychiatric Evaluation/Notes | <input type="checkbox"/> Psych testing |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> History and Physical | |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Physician Orders | |
| <input type="checkbox"/> Other (specify): _____ | | |

The amount of information to be disclosed is information covering (check as many as apply):

- Current or most recent episode Episodes occurring in the previous _____ months
 Other dates/episodes (specify): _____

The purpose or need for this disclosure is (check as many as apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> To Aid in Treatment | <input type="checkbox"/> To Inform Referral Source | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> To Inform Family | <input type="checkbox"/> To Inform Court System | _____ |
| <input type="checkbox"/> For Follow Up Care | <input type="checkbox"/> To Inform Employer/EAP | _____ |
| <input type="checkbox"/> At the request of the individual | <input type="checkbox"/> For treatment, payment, or operations purposes | |

I understand that this form is not required as a condition for treatment (except for certain court-ordered services) and that this authorization may be revoked any time except to the extent that action has been taken in reliance on it and may include information about future episodes or services occurring up to and including the expiration date of the release (unless revoked earlier). This authorization will expire one hundred and eighty (180) days after the date of my signature unless otherwise stated below. I understand that I may shorten or lengthen the authorization period at any time by notifying Netcare in writing. The release of information is limited to the person or organization named above and may include HIV/AIDS, mental health, drug & alcohol information, and gender identity information. This information may be released verbally and/or in writing via phone, fax, mail, or in person.

Specify date, event, or condition upon which the authorization will expire (expires 180 days from date signed if blank):

- 1 year from date signed Other date, event, or condition _____

I understand that information disclosed may be protected by law and may not be redisclosed without my written authorization or as otherwise authorized by law; however, I understand that Netcare cannot control the recipient's or any other person's use of the information after it is disclosed.

Prohibition on Redisclosure of Alcohol and Drug Abuse Patient Records (if applicable)

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 this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature of Client _____ **Date** _____ **Signature of Parent/Legal Guardian /Other authorized representative** _____ **Date** _____

COMPLETE ONLY IF APPLICABLE: Signature not obtained because (signature of two witnesses required):

- Person is incapacitated Medical Emergency/Continuity of Care Verbal Consent Obtained

Signature of Witness _____ **Date** _____ **Signature of Witness** _____ **Date** _____

COMPLETE ONLY IF APPLICABLE: I hereby revoke this authorization for release of information as of the date signed below:

Signature of Client _____ **Date** _____ **Signature of Parent/Legal Guardian /Other authorized representative** _____ **Date** _____