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):

☐ **Collateral information**
☐ **Treatment Progress**
☐ **MH/AOD Assessment**
☐ **Progress Notes**
☐ **Discharge Summary**
☐ **Current medication list**
☐ **Most recent psych note/psych discharge**
☐ **Psychiatric Evaluation/Notes**
☐ **History and Physical**
☐ **Physician Orders**
☐ **Nursing Assessment/Triage**
☐ **Psychological Report**
☐ **Psych testing**
☐ **Re-disclosure of records from Source:** _____ **Dated:** _____
☐ **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):

☐ **To Aid in Treatment**
☐ **To Inform Family**
☐ **For Follow Up Care**
☐ **At the request of the individual**
☐ **To Inform Referral Source**
☐ **To Inform Court System**
☐ **To Inform Employer/EAP**
☐ **For treatment, payment, or operations purposes**
☐ **Other (specify):** _____

I understand that this form is not required as a condition for treatment (except for certain court-ordered services), payment, enrollment or eligibility, 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)
42 CFR part 2 prohibits unauthorized disclosure of these records.

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**