Mid-Ohio Behavioral Health, LLC

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: ______________________ Date of Birth ______________________
Client Address: ______________________

I understand that all information, reports, and conversation concerning me are to be kept privileged and confidential. I understand that by signing this form, I am giving permission for Mid-Ohio Behavioral Health, LLC to (*check one*):

☐ **release** ☐ **receive** ☐ **exchange**

My health information, as specified below to: and release the above organization and affiliated individual from all legal liabilities that may arise from this situation.

Name of Person/Entity: ______________________
Address: ______________________
Street address City State Zip

Phone #: ______________________ Fax #: ______________________
Approximate Dates of Care and Treatment: ______________________
For the Purpose of *(check one):* ☐ Coordination of Services ☐ Emergency Contact

Specific description or information to be released (*check all that apply*):

☐ Diagnostic Assessment	☐ Diagnosis	☐ Treatment Plan
☐ Medication Progress Notes	☐ BH Progress Notes	☐ Case Management Progress Notes
☐ Genesight Report	☐ Discharge Summary	☐ Treatment Status and Recommendations
☐ Psychological Test Report	☐ Monthly Reports	☐ Psychiatric Evaluation
☐ Appointment Status	☐ Emotional Pet Support Letter	
☐ Labs/EKG Results	☐ TBS Progress Notes	☐ Medication List

Other: ______________________

This authorization will remain in effect for one year from the date of the signature unless otherwise stated.

I understand that the protected health information which is being used/disclosed is protected by Federal and State Law and may not be re-disclosed without my written authorization or as otherwise authorized by law. However, I understand that information being disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Mid-Ohio Behavioral Health LLC. This form has been fully explained to me and I certify that I understand its contents.

______________________ ______________________
Signature of Client Legal Guardian Date — Relationship to Client (*if applicable*)

______________________ ______________________
Print name (Client/Legal Guardian) Date — Witness signature Date

____
Print name (Witness)

I wish to revoke this authorization:

______________________ ______________________
Signature of client/guardian Date — Witness signature Date