

AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT NAME: _____ DATE OF BIRTH: _____

I hereby authorize:
Access Counseling Services, LLC

Name of individual, institution
4464 S. Dixie Hwy.
Address
Middletown, OH 45005
City & state

to
exchange
info
with

Name of individual, institution
Address
City & state

Address
Middletown, OH 45005
City & state

Address
City & state

Phone: (513)649-8008 Fax: (513)649-8004

Phone: _____ Fax: _____

I authorize the following information to be released:

- Diagnostic Assessment
Urine Screen/ Lab Results
Discharge Summary
Progress Notes
Treatment Plan
Other (specify):
Consultation
Other (specify):

Amount of information to be disclosed: (mark appropriate boxes)

- information covering the previous three months
information covering the most recent admission
other amount of information (specify)

This authorization includes release of records relating to: (mark appropriate boxes)

- Diagnoses and/or treatment for alcohol and/or drug abuse
HIV test results
AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment
Diagnoses and/or treatment relating to other communicable diseases

Indicate here any additional exceptions or exclusions, if any, to information released:

This authorization for use/disclosure is for the following purpose:

My refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, or enrollment in a health plan. This authorization will remain in effect for 90/180 days (circle one) unless an earlier date or condition/event is specified here:

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

NOTE: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules (ORC 5122.31, 42 CFR Part 2, and/or ORC 3701.243) 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 information to criminally investigate or prosecute any alcohol or drug abuse client.

Table with 3 columns: Signature of Client/Guardian/ Personal Representative, Date Signed, Print Name. Includes rows for Witness signature as well.

To Revoke

I understand that I have the right to revoke this authorization, at any time by submitting a written request to revoke authorization, and that the revocation will be effective except to the extent that Access Counseling Services, LLC has already taken action in reliance on my authorization.

I hereby revoke this authorization effective as of:

Table with 3 columns: Signature of Client/Guardian/ Personal Representative, Date Signed, Print Name.