AUTHORIZATION FOR MUTUAL DISCLOSURE

Family Service of Lucas County- 701 Jefferson Avenue #301, Toledo, OH 43604 (419) 321-6455 CL-05250LC

Client Name: _____ Date of Birth: _____ SS#: _____

I authorize Family Service of Lucas County, a service location of Family Service of Northwest Ohio to ☐ Obtain Information from, ☐ Disclose Information to, or ☐ Exchange Information with the Authorized Organization or Individual noted below:

_____ _____

(Name of authorized organization/individual to whom disclosure is made) (Address, phone number, and/or fax number)

The reason for this disclosure is:

☐Coordination of treatment services ☐ Aftercare planning ☐ Satisfy legal requirements ☐ Family support ☐ Billing/payment of Bill

☐Other: _____

The specific information to be disclosed is (check each specific item to be disclosed):

☐ Admission/ Biopsychosocial assessments
☐ Recommendations/prognoses
☐ Legal history/ Probation/ Parole information
☐ Psychiatric evaluation
☐ Medication sheets
☐ Medical history and physical and prior diagnosis
☐ Lab/Diagnostic/TB tests/ Drug and alcohol testing results
☐ Treatment plans/ Treatment summaries
☐ Progress Notes
☐ Treatment Dates
☐ Discharge summary/ Continuing care plan
☐ Psychological testing/ Assessment reports
☐ Other _____

I understand that the above checked items may include information regarding behavioral health treatment (mental health and/or substance abuse) that I may have received.

Amount of information to be disclosed: ☐ information covering all previous and current admissions ☐ information covering current information only ☐ information covering the previous 3 months ☐ specific dates: _____

This release will expire: ☐ 2 months ☐ 3 months ☐ 6 months ☐ other: _____ days/months after the date signed

OR The specific date or event/condition upon which this consent will expire is _____.

OR The formal and effective termination or revocation of my probation, or parole, or other proceeding under which I was mandated into treatment (for court mandated treatment).

The information released is for professional purposes only. Only the minimum amount of information needed to achieve the purpose may be disclosed. It may not be provided in whole or part to any other agency, organization or person, other than that which is stated above. I have read and agree that all information was properly completed prior to my signing this form, understand that this form is not required as a condition for treatment, and have the right to access the information to be disclosed. I have the right to shorten or lengthen the authorization period at any time. This authorization is subject to revocation at any time except to the extent that FSNO has already acted in reliance on it. The revocation must be in writing. I understand that FSNO cannot guarantee that the recipient will not disclose my health information to a third party and the recipient may not be subject to federal laws governing privacy of health information; however, if the disclosure consists of treatment information about alcohol or drug abuse treatment, the recipient is prohibited from re-disclosure under federal law (42 CFR, Part 2). See notice below.

_____ __/__/__ _____ __/__/__

(Client Signature) (Date) (Parent/Guardian/Authorized Representative Signature) (Date)

_____ __/__/__ _____ __/__/__

(Witness) (Date) (Parent/Guardian/Authorized Representative Printed Name) (Date)

Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by Federal Confidentiality rules. 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 C.F.R., 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. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.)

Renewal of Expired Authorization:

This authorization is renewed effective _____. The new expiration date is_____.

Signature:_____

Witness:_____

Revoked Authorization:

Client / Guardian has revoked this authorization as of

____/____/____.

Signature:_____

Witness:_____