

Unison Behavioral Health Group Inc.
Authorization for Disclosure/Consent to Release/Obtain Information

Agency Use Only Case Number: _____ <input type="checkbox"/> File Only <input type="checkbox"/> Request Information <input type="checkbox"/> Send Information Staff Completing Form: _____ _____
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Client Name: _____

Date of Birth: ____/____/____ Last four digits of Social Security# _____

In accordance with Federal Regulations 42 CFR part 2 and HIPAA, I hereby authorize:

Unison Behavioral Health Group Inc., 1425 Starr Ave, Toledo, Ohio 43605

to obtain records from: and/or to disclose and release records to:

Name of individual, institution: _____

Address (city/state/zip): _____

Phone: _____ Fax: _____

Information Hereby Authorized to Be Released

- | | | | | |
|---|--|--|--|-------------------------------------|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Diagnostic Assessment | <input type="checkbox"/> Lab Results | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Medication Orders | <input type="checkbox"/> Drug Screen Results | <input type="checkbox"/> Attendance |
| <input type="checkbox"/> Physical Health Progress Notes | <input type="checkbox"/> Demographics | <input type="checkbox"/> Alcohol/Drug Progress Notes | | |
| <input type="checkbox"/> Alcohol/Drug Assessments | <input type="checkbox"/> Alcohol/Drug Treatment Plan | | | |
| <input type="checkbox"/> Alcohol and Drug Other: _____ | <input type="checkbox"/> Other: _____ | | | |

For the Time Period of: (Choose one only)

- Most Recent Admission All Admissions Previous Six Months Time period of _____ to _____ (dates required)

Including psychiatric records related to emotional illness, and information regulated by federal public law 930-282, Confidentiality of Alcohol and Drug Abuse Patients. Also included are records documenting the diagnosis and/or treatment of AIDS, ARC, HIV Positive and other related diseases.

Purpose of Disclosure: (Check one or more):

- Comprehensive Treatment Family Involvement Aftercare/Follow-up Legal Issues Continuity of Care
 Other: _____

Re-Disclosure:

The confidentiality of the information being disclosed is protected by State and Federal law. ORC 5122.31, ORC 3701.243 and 42 CFR part 2 prohibit you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, his/her authorized representative, or as otherwise permitted by law. 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 information to criminally investigate or prosecute any alcohol or drug abuse client.

Expiration:

This Authorization will automatically expire in six months (180 days) after the date of the authorization, unless one of the following is checked:

- I expect to continue receiving services beyond one hundred eighty (180) days and extend the authorization to a maximum of one (1) year or at service termination, whichever is sooner.
 Specific date or date range to a maximum of one (1) year or at service termination, whichever is sooner here: _____

Extension of Expiration

This Authorization can remain in effect for up to six (6) months after service termination for information authorized to be released as selected above. Please mark below if extension of expiration is needed.

- I expect to need information related to above released after service termination. This extension will be in effect for six (6) months after termination unless revoked.

I understand I can refuse to sign this authorization. I understand Unison Behavioral Health Group, Inc. may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that the information disclosed is protected by law and should not be re-disclosed without my written authorization or as otherwise authorized by law; however, I understand that Unison Behavioral Health Group cannot control the recipient's use of the information, and I hereby release Unison from any liability for the recipient's re-disclosure of such information.

I understand that this authorization may be revoked by me at any time, except to the extent the program or person who is to make the disclosure has already acted in reliance on it. The revocation must be signed and dated by me. Upon revocation of consent, further release of information shall cease immediately.

Signature of Client/Guardian*/Authorized Representative* and authority to act on client's behalf Date

*If other than the client, relationship to the client is: Parent Guardian Other: _____

Revocation:

Upon revocation of consent, further release of information shall cease immediately. I hereby revoke my consent for release of the above information.

Signature of Client/Guardian*/Authorized Representative* and authority to act on client's behalf Date

*If other than the client, relationship to the client is: Parent Guardian Other: _____