



**AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORD INFORMATION**

<u>Revocation only</u>	<u>Internal Use Only</u>
<input type="checkbox"/> Verbal <input type="checkbox"/> Written	<input type="checkbox"/> File: Do not send information at this time <input type="checkbox"/> Send documents upon signature of client

Client Name (First, Middle, Last) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Dates of Service to be Released: \_\_\_\_\_ to \_\_\_\_\_

**RELEASE INFORMATION TO:**  
I hereby authorize Zepf Center 6605 W. Central Avenue, Toledo, Ohio 43617 to:  
 obtain from or  release to or  share/disclose with

**Check only one:**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Columbia Gas                                  | <input type="checkbox"/> Lucas County Sheriff's Office         | <input type="checkbox"/> St. Paul's Community Center    | <input type="checkbox"/> Sylvania Municipal Courts       |
| <input type="checkbox"/> Department of Jobs and Family Services (DJFS) | <input type="checkbox"/> Lucas Metropolitan Housing (LMHA)     | <input type="checkbox"/> St. Vincent Medical Center     | <input type="checkbox"/> Unison Behavioral Health Group  |
| <input type="checkbox"/> Family Services of NW Ohio                    | <input type="checkbox"/> Lutheran Social Services              | <input type="checkbox"/> Social Security Administration | <input type="checkbox"/> Washington Local Schools        |
| <input type="checkbox"/> Flower Hospital                               | <input type="checkbox"/> Neighborhood Health Association (NHA) | <input type="checkbox"/> Sylvania Municipal Courts      | <input type="checkbox"/> Probation/Parole Officer: _____ |
| <input type="checkbox"/> Harbor  | <input type="checkbox"/> Neighborhood Properties Inc. (NPI)    | <input type="checkbox"/> Toledo Edison                  | <input type="checkbox"/> Primary Care Physician: _____   |
| <input type="checkbox"/> Juvenile Detention _____                      | <input type="checkbox"/> Rescue Mental Health Services         | <input type="checkbox"/> Toledo Hospital                |  |
| <input type="checkbox"/> Lucas County Board of DD                      | <input type="checkbox"/> St. Charles Hospital                  | <input type="checkbox"/> Toledo Municipal Courts        |  |
| <input type="checkbox"/> Lucas County Children's Services              | <input type="checkbox"/> St. Luke's Hospital                   | <input type="checkbox"/> Toledo Public Schools (TPS)    |  |
| <input type="checkbox"/> Lucas County Court System                     |  |   |  |
| <input type="checkbox"/> Other: _____                                  |  |   |  |

(Include Complete Name of Person/Entity and address including City, State and Zip Code)

**INFORMATION TO BE RELEASED & PURPOSE:**

By signing this form, I voluntarily authorize access, use and disclosure of my: (initial each of the following you authorize)  
\_\_\_\_\_ Mental health diagnosis and treatment information  
\_\_\_\_\_ HIV/AIDS/ARC Testing and/or Status  
\_\_\_\_\_ Alcohol & other drug diagnosis and treatment information  
\_\_\_\_\_ Genetic Testing

**Check the following information to be released (check all that apply):**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Entire medical record (does not include HIV/AIDS/ARC Testing and/or Status, Genetic Testing or Alcohol and Other Drug diagnosis and/or treatment information unless initialed above.) OR | <input type="checkbox"/> Medical Progress Notes | <input type="checkbox"/> Psychiatric Diagnostic Evaluations |
| <input type="checkbox"/> Diagnostic Assessment  | <input type="checkbox"/> AOD Progress Notes     | <input type="checkbox"/> CPST/Case Management Notes         |
| <input type="checkbox"/> Medications  | <input type="checkbox"/> Diagnosis              | <input type="checkbox"/> Written Letter / Correspondence    |
| <input type="checkbox"/> Attendance Records   | <input type="checkbox"/> Other: (specify) _____ |   |
| <input type="checkbox"/> Therapy Summary  |   |   |

**Purpose: The information shared will be used: (check all that apply)**

- |  |  |
|--|--|
| <input type="checkbox"/> To help with my treatment and care coordination | <input type="checkbox"/> To assist the provider or organization to improve the way they conduct work |
| <input type="checkbox"/> To help pay for treatment                       | <input type="checkbox"/> To help me apply for benefits or assistance with utilities or housing       |
| <input type="checkbox"/> Legal   | <input type="checkbox"/> Other (specify) _____   |

**EXPIRATION OF DISCLOSURE:**

This authorization for the release/obtaining of information will automatically expire in six months (180 days) after the date of authorization unless I expect to continue receiving services beyond the 180 days and extend the authorization to a maximum of one year (365 days) after the date of authorization as indicated below:

Expiration date: \_\_\_\_\_ Condition date or event of earlier / later expiration: \_\_\_\_\_

- I understand that the information disclosed is protected by law and may not be redisclosed without my written authorization or as otherwise authorized by law. However, I understand that Zepf Center cannot control the recipient's use of the information.
- I understand that authorizing the use of disclosure of the above information is voluntary and Zepf Center will not condition treatment, payment, enrollment, or eligibility for benefits on the execution of this Authorization.
- I understand that this authorization can be revoked by me or my authorized agent at any time, except to the extent that action has been taken by Zepf Center in reliance on the authorization and that the revocation must be in writing and signed and dated by me or my authorized agent (upon revocation of consent, further release of information shall cease immediately. A verbal revocation may serve until a written revocation can be obtained by calling Zepf Center: 419-841-7701 and speaking with a Release Clerk.
- For more information about your privacy rights, please refer to Zepf Center's HIPAA Notice of Privacy Practices and 42 CFR Part 2 Summary Sheet.

\_\_\_\_\_  
Signature of Client or Legally Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Authorized Agent (if different than Client)

\_\_\_\_\_  
Name of staff member facilitating this response

**CONFIDENTIALITY STATEMENT:** This information has been "disclosed to you from records protected by Federal confidentiality laws. 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."

I hereby revoke my consent for release of information above: \_\_\_\_\_  
Signature of Client or Legally Authorized Representative Date

Staff Member Facilitating Revocation (Written or Verbal) \_\_\_\_\_ Effective Date: \_\_\_\_\_