**Authorization to Use or Disclose Protected Health Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name-Please Print

**Authorize:** St. Paul’s Community Center – 230 13th Street – Toledo Ohio 43604 419 255 5520

🞎 **To Release/Disclose to:** 🞎 **To Obtain Information from:** 🞎 **To Permit Verbal Disclosure:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Individual, Facility, or Organization-Please Print Address Phone

Dates of Information to be Disclosed or Obtained: Start date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_End Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The Purpose of the disclosure is:**

🞎 Housing 🞎 Reasonable Accomodations 🞎 Court/Legal 🞎 Insurance

🞎 Verbal Exchange 🞎 Continued Treatment 🞎 Disability 🞎 Progress Updates

🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be used or disclosed:**

🞎 Discharge Summary 🞎 History/Mental Health/AoD 🞎 Notice of Services

🞎 Treatment Referral 🞎 Return to Work 🞎 Progress Notes 🞎 Diagnosis

🞎 Current Medication 🞎 Psychiatric evaluation 🞎 Physical evaluation

🞎 bio-psychosocial assessment 🞎 Service/treatment plan

🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This authorization includes release of records related to:**

🞎 Mental Health 🞎 Chemical Dependency/Abuse Treatment/AoD

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 effective for 180 days unless an earlier date or condition is specified here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. However, I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that SPCC has already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be given to my CPST or SPCC staff and will be documented and placed in my file.

I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient and to be no longer protected by the Federal HIPAA law.

\*\*Drug and Alcohol records: 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 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 by client.

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Signature of Individual/Guardian/Personal Representative Date Relationship to Client if not the Client

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SPCC staff Date