Unison Health

Authorization for Disclosure/Consent to Release/Obtain Information

Agency Use Only
Case Number: _____

Staff Completing Form:

_____

Client Name: _____

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

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

Unison Health, 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

☐ Medical Progress Notes ☐ Clinical Progress Notes ☐ Lab Results ☐ Attendance
☐ Diagnosis ☐ Discharge Summary ☐ Assessments
☐ Treatment Plan ☐ Medications ☐ Drug Screen Results

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 one (1) year after the date of the authorization, unless the following is checked:

☐ 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 Health 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 Health 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: _____