Authorization to Release Information

Patient Information

Client Name: _____ Client ID: _____

DOB: _____ Effective Date: _____

General

Zepf Center abides by all federal and state confidentially laws including HIPAA (Health insurance Portability & Accountability Act), and 42 CFR Part 2. By signing this authorization, I acknowledge, accept and agree.

This information has been disclosed to you from records in which confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) Prohibit the recipient from making any further disclosure of it without the specific written consent of the person whom it pertains or except as otherwise permitted. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Information disclosed under 42 CFR Part 2 cannot be used to criminally investigate or prosecute any patient with a substance use disorder except as provided for in 42 CFR Part 2.

Release To / Release From

Name or Other Specific Identification of Person(s) authorized to receive/ make the requested use or disclosure:

☐ Organization/Provider ☐ Personal Contact **Type:** ☐ Release To/Share With ☐ Obtain From

Release To/From:

Organization / Provider Name: _____

Name or Title of Person to Receive Information (if applicable): _____

Name of Personal Contact: _____

Relationship to Patient (if applicable): _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ Fax Number: _____

Purpose of Disclosure

☐ Care Coordination and Treatment
☐ Advocacy with Benefits/Assistance
☐ Legal
☐ Organizational Improvement
☐ Payment for Treatment
☐ Transportation
☐ HIE (Health Information Exchange)
☐ Other: _____

Expiration

If nothing marked – one (1) year from date signed

☐ 90 days ☐ 6 months ☐ 1 year

Start Date: _____ **End Date:** _____

Information to be Used or Disclosed

The information that may be disclosed under this authorization includes the following, if available

ROI Type: ☐ MH ☐ SUD ☐ General: Both MH and SUD

☐ Acknowledgement of Treatment ☐ Attendance ☐ Billing &/or Insurance Information

☐ Diagnosis Only ☐ Discharge Summary Plan ☐ Diagnostic Assessment/DA Update

☐ Drug Screen Results ☐ Genetic Testing Analysis/Results ☐ Lab Results, Immunization Records

☐ Medical History ☐ Medications Prescribed ☐ Progress Notes (Med, Case Mgmt, SUD Counseling, as applicable)

☐ Progress Review/ Summary ☐ Psych Testing ☐ Psychological Evaluation(s) Reports

☐ School Records/Reports/IEPs ☐ Screening Assessment(s) ☐ Therapy Notes

☐ Treatment Plan(s)/Waiver PIC (All Documents)

☐ Other (specify all that apply):_____

_____

Records Start Date: _____ **Records End Date:** _____

Restrictions

Please identify any restrictions to the above if applicable:_____

_____

Terms

- Under state and federal confidentiality provisions only the information specified may be released.
- Zepf Center cannot ensure the recipient will maintain the confidentiality of the mental health and/or SUD information authorized and released. If the person or organization obtaining this information is not a health care provider, health plan or covered under the federal privacy regulations, the information may no longer be protected by federal privacy laws including 42 C.F.R. Part 2 and could be re -disclosed.
- This authorization will be honored unless revoked in writing. Revocation may be made at any time except to the extent action has already been taken.
- This authorization will expire in one (1) year from the date of signature, or 90 days from the date of discharge from the agency unless otherwise indicated above.
- This authorization is voluntary. I have been given the chance to ask questions and receive answers pertaining to this document.
- A list of entities to which my information has been released can be provided by Zepf Center.

By checking these boxes, I agree that I have read, understand and agree to these terms.

☐ NOTICE TO CLIENT: I understand that I will not be denied treatment, payment, enrollment, or eligibility if I refuse to sign this authorization.

☐ ACCESS TO MY RECORD: I understand I may request a copy of my record and this authorization. This request will be reviewed and approved by provider. I understand I may also review my records with my provider by making an appointment. This request may take 30 days to complete and charges will apply.

Agency Contact Information

Attention: Medical Records **Phone:** 419-841-7701

Address: 6605 W. Central Avenue Toledo, OH 43617

Other:

Copy Given to Client: ☐ Yes ☐ Declined a copy **Agency Staff:** _____

ID Verified By: ☐ Driver's License ☐ State ID ☐ Other Picture ID ☐ Known to Agency

Additional Information

Please note – The records released may contain substance use and addiction treatment information, genetic testing, and/or information about Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC).

Substance Use / Addiction Treatment:

☐ I authorize the release of information relating to referral, diagnosis, and/or treatment for substance use / addiction treatment.

☐ I PROHIBIT the release of information relating to referral, diagnosis, and/or treatment for substance use / addiction treatment.

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease

☐ I authorize the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

☐ I PROHIBIT the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

Signatures

_____ _____

Patient/Guardian Signature Date

_____ _____

Workforce Member facilitating request Signature & Credentials Date

Revised 02/2022