

Symmetry Wellness

Authorization to Disclose / Obtain Confidential Information (Mental Health Services)

CLIENT NAME: (first, middle, last) _____

DATE OF BIRTH: _____

S.S. #: _____

In accordance with Federal Regulations 42 CFR, Part 2 and HIPAA, I hereby authorize Harbor Behavioral Healthcare

to obtain from: to release/disclose to:

HARBOR BEHAVIORAL HEALTHCARE
Symmetry Wellness
4334 Secor Road
Toledo OH 43623

Name of individual/entity to whom disclosure is to be made: _____
(provide full name)

Address (city/state/zip): _____
(provide complete address)

Identify and describe nature/extent of information to be disclosed (as limited as possible):

for dates of services including: _____ to _____

(Including psychiatric records related to emotional illness, and information regulated by Federal Public Law 930-282, confidentiality of alcohol and drug abuse clients. Also included are records documenting the diagnosis and/or treatment of AIDS, ARC, HIV Positive and other related diseases.)

PURPOSE FOR DISCLOSURE AS SPECIFIC AS POSSIBLE: (check one or more):
 comprehensive treatment family involvement aftercare/follow-up legal issues other: _____
(explain/identify)

AS REQUIRED BY SECTION 2:32(2) PROHIBITION OF REDISCLOSURE RULES: The enclosed information is protected by Federal Confidentiality Rules (42 CFR Part 2) and/or Ohio law (O.R.C. 5122.31; O.A.C. 5122-27-09). The Federal Rules and Ohio law 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 is otherwise permitted by 42 CFR Part 2 and applicable Ohio law. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

I understand that my treatment payment for my services, my enrollment or eligibility for benefits cannot be conditional upon my giving authorization for disclosure of information for any other purpose.

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 Harbor Behavioral Healthcare cannot control the recipient's use of the information.

This Authorization to Disclose/Obtain Confidential Information will automatically expire in six months (180 days) after the date of authorization unless:

I expect to continue receiving services beyond 180 days and extend the authorization to a maximum of one (1) year (365 days) or at termination, whichever is sooner.

Expiration date is: _____. Condition, date or event of earlier/later expiration: _____

Name and signature of staff facilitating this request: _____

I understand that I and/or my parent/guardian, if appropriate, may revoke this authorization at any time, except to the extent that action has been taken in reliance on it, and that the revocation must be signed and dated by me, my parent/ guardian/authorized representative. Upon revocation of consent, further release of information shall cease immediately.

Signature of Client: _____ Date: _____

Signature of Parent/Guardian/Authorized Representative and authority to act on client's behalf: _____

Description of Relationship: _____

I hereby revoke my consent for the release of the above information.
Date: _____ Signature: _____

NOTATION OF RECORDS SENT: *complete Record of Disclosures Authorized by Client, Parent/Guardian, Authorized Representative*