Release of Information and Authorization To Disclose Protected Health Information, Mental Health

(Please answer all questions. Leaving any blank spaces invalidates this authorization.)

Authorization to Disclose Information Regarding:

(Full name of Client)

Date of Birth:	

I hereby give permission for:– Beechacres Parenting Center Ricka' Berry ——

(Name or Names of Persons Disclosing Information)

6881 Beechmont Ave	Cincinnati Ohio 45230

(Street Address) *(City, State, and Zip Code)*

to release my health information, as specified below, to:

(Name or Names of Persons Securing Information)

(Street Address) *(City, State and Zip Code)*

I authorize the following specific information to be disclosed: (Check in the Y box for Yes and N box for No.

Y N		Y N	
☐☐	Diagnostic Assessment	☐☐	Individual Service Plan (treatment plan)
☐☐	Psychiatric Evaluation	☐☐	Psychiatric Dictation
☐☐	Discharge Summary	☐☐	Verbal exchange of treatment information

☐ Other (specify):

Amount of information to be disclosed

- ☐ information covering the previous three months
- ☐ information covering the most recent admission
- ☐ information from beginning to present
- ☐ other amount of information (specify) ____

This authorization for use/disclosure is for the following purpose **(check those that apply)**

- ☐ to ensure continuity of care
- ☐ report client progress
- ☐ to verify client attendance at activities
- ☐ determine eligibility for other services
- ☐ at the request of the individual
- ☐ other____

Except as limited as follows**:**

n/a

(write N/A if not applicable)

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A consent is valid for 90 days for a one time release of information. Otherwise this consent shall expire in six months from the date of its completion (the date next to the client's signature below) unless I agree to an expiration date of one year as indicated below. You may shorten or lengthen the authorization period at any time, which will require a new release be written.

SELECT ONLY ONE OF THE FOLLOWING

This consent expires in 90 days on the following date: ________________

This consent expires in six months on the following date: ________________

This consent expires in one year on the following date: ________________

I have elected a period of time for expiration other than the above and the consent expires on the following date: ________________

This consent may be revoked at any time.

My refusal to sign this authorization will not affect my ability to obtain treatment, payment, or enrollment in a health plan. I understand that there is potential for this information to be redisclosed by the recipient.

However, I understand that I have the right to revoke/withdraw this authorization, in writing, at any time, and that the revocation/withdrawal will be effective except to the extent that Beech Acres has already taken action in reliance on my authorization. My written statement that I want to revoke/withdraw my authorization should be delivered to Ricka Berry, Beech Acres Privacy Officer, 6881 Beechmont Ave., Cincinnati, OH 45230

____	______________________________
(Signature of Client or Person Authorizing Disclosure)	*(Date the Consent Takes Effect)*
____________________________________	____________________________________
(Authority of Person Authorizing Disclosure)	*(Name of Staff Member Facilitating this Authorization)*

THIS BOX IS COMPLETED ONLY IN THE CASE WHERE THE AUTHORIZATION HAS BEEN REVOKED

____	______________________________
Name of staff Person to whom the Revocation was Communicated (PRINT THE NAME)	Date of Revocation