Release of Information and Authorization To Disclose Protected Health Information, Mental Health
(Please answer all questions. Leaving any section blank invalidates this authorization.)

Client Information

Client Full Name:_____

Date of Birth :_____

Name of Client/Parent/Legal Guardian Completing Form :_____
(PRINT)

Release To

I hereby give permission for Beech Acres Parenting Center, (select location)

☐ 6881 Beechmont Ave Cincinnati OH 45230 ☐ 3325 Glenmore Ave Cincinnati OH 45211 ☐ 767 Columbus Ave Suite 2 Lebanon OH 45036

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

Name:_____ Organization(if applicable):_____

Street Address:_____City/State:_____

Zip Code:_____ Telephone Number:_____

Information to Release

I authorize the following specific information to be disclosed: (check all that apply)

☐ 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 from beginning to present ☐ Information from the most recent admission

☐ Information from the previous three months ☐ Other amount of Information (specify)_____

***Please indicate any restrictions on information to be released:**_____ **(write N/A if not applicable)**

Purpose

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:_____

Client/Parent/Legal Guardian Authorization

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 expiration date (MM/DD/YY): 90 days_____6 months _____1 year_____

Other elected time period_____

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 re-disclosed 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 Parent/Guardian Authorizing Disclosure Date the Consent Takes Effect

_____ _____
Authority of Person Authorizing Disclosure Signature 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) Date of Revocation