This form expires 2 years from the date of signature unless otherwise revoked before that time

HOPE419

PSYCHIATRY and COUNSELING

ASHLAND-ONTARIO-NORWALK-WOOSTER

419-951-2020 Phone/Fax

PLEASE NOTE: ALL PARTS OF THIS FORM MUST BE COMPLETED AND SIGNED IN ORDER FOR ANY RECORDS TO BE SENT OR RECEIVED.
REQUESTS FOR RECORDS FOR TEENS REQUIRE SIGNATURES FROM BOTH THE PATIENT AND THE ADULT GUARDIAN.

Hope419, LLC Authorization for Release of Information

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

I authorize Hope 419 to exchange information with:

Name: _____

Address: _____

Phone: _____ Fax: _____

PURPOSE OF THIS REQUEST: ☐ **Healthcare** ☐ **Insurance Coverage** ☐ **Personal** ☐ **Other**

TYPE OF RECORDS AUTHORIZED:

- ❑ **Psychiatric/Psychological Evaluation and/or Treatment**
- ❑ **Drug/Alcohol Evaluation and/or Treatment**

SPECIFIC INFORMATION AUTHORIZED: (circle one or more as appropriate)

ALL INFORMATION CAN/SHOULD BE EXCHANGED AS NECESSARY

Assessments	Progress Notes	Laboratory TestResults
Diagnostic Impression	Discharge Summary	Treatment Plans
Treatment Summary	Other: (please describe)_____	

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire when I am no longer receiving services from Hope 419.

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a *written* request to Hope419.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

Signature of Patient or Representative: _____ Date:_____

Printed Name of Person Signing Form:_____

Relationship to Patient (*if requester is not the patient)*: Parent Legal Guardian Other: _____

Signature of Patient (required if age 13 or older) _____ Date_____