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_____