South Community
Positive Health Options

Authorization For Release/Exchange of Information

Medical Records: 3095 Kettering Boulevard
Dayton, Ohio 45439
Phone: (937) 534-1358 Fax: (937) 534-1348

SCI Client ID#: _____

I, _____ ,hereby grant permission to authorized representatives of South Community Inc. to

(check one) ☐ RELEASE TO ☐ RECEIVE FROM ☐ EXCHANGE WITH

Name: _____

Address: _____

_____

Phone: _____ Attention: _____

Note: Specific Person's name required for SUD Records

Information checked below regarding the following individual:

Name: _____ _____ _____ DOB: _____

Last Name **First Name** **MI**

I authorize the disclose of the following information:

- ☐ Mental health diagnosis
- ☐ Discharge Summary
- ☐ Bio-psychosocial history
- ☐ Psychological/Academic Testing
- ☐ Psychiatric Evaluations
- ☐ Medication History
- ☐ Current Medications
- ☐ Laboratory Reports
- ☐ Treatment Plans
- ☐ Progress Notes
- ☐ Schedule of Appointments
- ☐ Emergency Room Treatment
- ☐ Urinalysis Results
- ☐ Substance Abuse Diagnosis _____ (initial)
- ☐ Substance Use History _____ (initial)
- ☐ Substance Use Treatment _____ (initial)
- ☐ Any ***Mental Health Only*** information pertinent to assessment and provision of ongoing treatment and continuity of care
- ☐ Other: _____

I agree that this authorization shall remain in effect as indicated below:

- ☐ until the end of treatment; or
- ☐ until an expiration date listed here: _____
- ☐ OTHER condition/event (please specify): _____

This authorization specifically pertains to information regarding treatment which occurred _____ to _____.

For records related to mental health services, information from other providers contained in the client records (EHR) may be released with this written authorization. For records related to substance abuse services, information within the EHR from other providers may be released only if written authorization explicitly authorizes the re-disclosure by initializing above.

I understand that I may revoke this authorization for release of my information to the party listed below at any time by my written notification. Upon revocation of this consent, further release of information will cease immediately, except for those situations not protected by law.

I understand that signing this authorization is voluntary. Failure to sign or cancellation of this authorization will not prevent me from receiving services for which I am entitled, provided this information is not required to determine if I am eligible to receive these services.

Name used when treatment occurred: _____ First _____ MI _____ Last

_____ Client Signature _____ Date _____ Phone Number

_____ LEGALLY RESPONSIBLE OTHER _____ Date _____ Phone Number

_____ RELATIONSHIP, IF NOT CLIENT _____ STAFF FACILITATING REQUEST

PLEASE NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by State and Federal law. ORC 5122.31. 42 CFR Part 2, and/or ORC 3701.243 prohibited further disclosure of it without the specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is NOT sufficient for this purpose.

All matters relating to **Alcohol or Drug Abuse Patient Records** are considered privileged. Federal Law 42 CFR, Part 2 prohibits further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigative or prosecute any alcohol or drug abuse client.

REVOCATION OF AUTHORIZATION FOR RELEASE OF INFORMATION

Effective _____, I hereby withdraw permission for the release of information related to my care from and to the parties above. Further release of information shall cease immediately.

_____ Client Signature _____ Date _____ Legally Responsible Other _____ Date

Authorization For Release/Exchange of Information

Procedures

Before releasing client Protected health Information (PHI), a complete and adequate Electronic Health Record (EHR) shall contain a signed Authorization for Release/Exchange of Information not otherwise mandated by law or as specified under Policy regarding Consent for Treatment.

Each specific request for release of information shall be accompanied by a completed and signed Authorization for Release/Exchange of Information which shall include, but not be limited to the following:

- A statement that this information is not to be further disclosed without the specific written authorization of the client/guardian
- The Authorization for Release/Exchange of Information will remain in effect for (60) days or until the end of treatment or until an expiration date is specified. Client shall designate their choice
- The name and address of the agency disclosing the information
- The name and address of the person, institution or agency receiving the information
- The purpose or need for disclosure
- The extent and nature of the information to be disclosed
- If the client is 14 years old or older, client must sign an authorization to release SUD-related PHI to the parent/guardian

For clients with drug and alcohol problems, even if those problems are not the primary problem under treatment, all Federal regulations regarding the release of information for such cases must be followed. (FEDERAL REGISTER, VOLUME 52, NUMBER 110, 6/9/87, CFR part 2). This must contain:

- The full name and date of birth of the client
- The clients who are 14 years or older will need to sign the Authorization to Release if SUD-related information is to be disclosed
- The written signature of the parent/legal guardian and his/her relationship to the client if the client is a minor
- The date on which the authorization was signed
- The name of the staff person facilitating the client's Authorization for Release/Exchange of Information

For clients who are part of an approved research study that requires an Authorization for Release/Exchange of Information beyond the designated period, another Authorization for Release/Exchange of Information must be signed for each designated period.

PHI can be shared according to the specific requirements without your prior authorization in the following situations:

- HIPPA regulations authorize the exchange of PHI among health care providers for treatment purposes. Ohio's mental health law/HIPAA authorizes the exchange of psychiatric treatment information between community mental health agencies and other health care providers for purposes of continuity of health care such as private therapists, psychologists or psychiatrists, primary care providers, health specialist; and Medicaid managed care plans.
- IN AN EMERGENCY. In situations requiring immediate medical or psychiatric response (health or safety issues are involved).
- FOR MEDICAL MANAGEMENT. For instance, SCI staff may assist you in getting your medication by working with an area pharmacist or laboratory;
- WHEN REQUIRED BY LAW.
    i. For public health activities
    ii. To protect victims of abuse, neglect or domestic violence
    iii. For health oversight activities
    iv. Court order
    v. To a coroner/medical examiner
    vi. To avert serious threats to health or safety
    vii. To facilitate specialized governmental functions
- When there are SUBSTANTIAL COMMUNICATION BARRIERS and it is reasonable to believe that the client/guardian is giving authorization.

Authorization for Release/Exchange of Information will automatically expire as indicated by the client's designated choice unless an earlier date, event or condition is specified.

When information is released from the client's record, the original signed Authorization for Release/Exchange of Information shall be retained in CATT DMS under Correspondence/authorizations which identifies the specific information allowed to be released, the date of the release, to whom it was released and the signature of the person releasing the information.

The Authorization for Release/Exchange of Information can be revoked at any time by the client or his/her parent/legal guardian where applicable.

i. Revocations of the Authorization of Release of Information shall be signed and dated by the client or the client's parent/Legal guardian where applicable.
ii. Upon revocation of the Authorization of Release of Information, further release of information shall cease immediately.