Authorization to Release Medical, Mental Health and Substance Abuse Information

Patient name:_____Date of birth:_____/____/_____Phone:

Address/city/state/ZIP:_____Program: ☐Inpatient ☐PHP ☐IOP

Please release requested information TO/FROM:	Please release requested information TO/FROM:
	SUN Behavioral Columbus 900 East Dublin Granville Road Columbus, OH 43229
Attn.:	Attn.:
Phone:	Phone: 614-706-2786
Fax:	Fax: 614-796-0496

I give my authorization for SUN Behavioral staff to speak with _____ about my treatment and/or benefits/financial information.

Dates of Treatment being requested:

The recipient of the information released may use it only for the following purposes (must be indicated):

____ Continuum of care ____ Disability ____ Insurance ____ Legal purpose/court ____ School/educational needs
____ Military ____ Other – please specify: _____

Information to be RELEASED: I authorize SUN Behavioral to release and discuss medical records including (any information related to medical, surgical, psychological, social, psychiatric, drug and/or alcohol abuse, diagnosis, treatment, prognosis and/or therapy) therein contained. INITIAL:_____The information authorized for release may include information about communicable or venereal diseases, which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome. INITIAL: _____

____ Discharge summary ____ Initial psychiatric evaluation ____ History & physical ____ Orders ____ Labs
____ Discharge paperwork ____ Medication information ____ Benefits/financial
____ Other – please specify: _____

How would you like to receive your information?_____Mail_____Pick-up_____Fax_____Email: _____

- Upon presentation to pick up information or complete an authorization a request for identification will be made to ensure validity/authority of the receiving party**. When faxing or emailing ROI, please attach copy of ID.**

In compliance with all state confidentiality/privacy statutes/regulations regarding the release of mental health information and federal confidentiality rules in 42 CFR Part 2 regarding release of substance abuse treatment information:

1. This authorization is subject to revocation at any time. Revocation can be given orally or in writing.
2. If not previously revoked, the patient's consent to release mental health and/or substance abuse information will expire 90 days (3 months) after the date of this release unless otherwise noted here:_____.
3. This authorization is in effect until the expiration date, event or condition is met and regardless of whether the patient is still receiving services from the provider.
4. If requested, the patient is entitled to an accounting of the disclosures of their protected health information.
5. My treatment, payment, enrollment, eligibility for benefits will not be conditioned on whether I sign this authorization.

Patient's signature: *(includes minors 16 years)*	Date:	Time:
Parent/legal guardian's signature: *POA or legal representative, please provide copy of legal documents*	Date:	Time:
Responsible party phone number: Home: Work:	Cell:	
Witness signature:	Date:	Time:

NOTE TO RECEIVER: The information that is being disclosed is confidential and protected by federal law. The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations, including HIPAA and 42 CFR, Part 2, which prohibits the receiver of this information from making any further disclosure of same, except with the written authorization of the person to whom it pertains. A GENERAL AUTHORIZATION for the release of medical/psychiatric information is not sufficient for this purpose. Federal laws and regulations restrict any use of the information to investigate or prosecute about a crime of any patient with a substance use disorder, except as provided at §§2.12(c) (5) and 2.65.

STAFF ONLY:

Information disclosed:_____Staff signature:_____Date:_____