SOLUTIONS
Community Counseling and Recovery Centers

975 A Kingsview Drive
Lebanon, OH 45036
513-228-7800
(FAX#513-228-7846)

975 B Kingsview
Lebanon, OH 45036
513-228-7800
(FAX#513-228-7857)

50 Greenwood Lane
Springboro, OH 45066
937-746-1154
(FAX# 937-746-8523)

953 S. South St.
Wilmington, Ohio 45177
937-383-4441
(FAX# 937-383-2916)

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name _____ **Date of Birth** _____

Phone Number _____ **Client Number** _____

Client Address _____

If you receive information released with this form the following Federal Law applies directly to you:
This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. Upon request and consistent with this part, a client will be provided a list of entities to which their information has been disclosed pursuant to the general designation

I AUTHORIZE SOLUTIONS COMMUNITY COUNSELING AND RECOVERY CENTERS, TO RELEASE TO, OBTAIN FROM, or EXCHANGE WITH THE ORGANIZATION INDICATED BELOW CONCERNING TREATMENT OF THE ABOVE NAMED CLIENT. THIS AUTHORIZATION INCLUDES RELEASE OF INFORMATION CONCERNING HIV TESTING OR TREATMENT OF AIDS, AIDS-RELATED CONDITIONS, ALCOHOLISM, DRUG ADDICTION AND/OR PSYCHIATRIC/PSYCHOLOGICAL CONDITIONS. Please be advised: **AN ASSESSMENT IS COMPREHENSIVE AND MAY INCLUDE BOTH MENTAL HEALTH AND SUBSTANCE USE INFORMATION.**

THE PURPOSE OF THIS RELEASE IS TO:
☐ Coordinate Treatment ☐ Assessment Information for Treatment Planning ☐ Information for Ongoing Treatment
☐ Other Purposes (specify): _____

TYPE OF INFORMATION TO BE DISCLOSED: ☐ **MH only** ☐ **SUD only** ☐ **Both MH and SUD**
☐ Discharge Summary ☐ Treatment Plan ☐ Past Medications ☐ Attendance
☐ Diagnostic Assessment ☐ Treatment Summary ☐ Current Medications ☐ Psychiatric Evaluation
☐ Psychological Evaluation ☐ Medical Information ☐ Rehabilitation Reports ☐ Scheduling/Appointments
☐ Any Drug and Alcohol Information
☐ Any other information pertinent to the treatment of this client (Specify): _____

AMOUNT OF INFORMATION TO BE DISCLOSED:
☐ Information covering the previous three months ☐ Information covering the most recent admission
☐ Other amount of Information (Specify) _____

Name of Organization/ Person	
Address	
City/State/Zip	
Telephone Number	
Attention	

THE ABOVE INFORMATION IS RELEASED TO, OBTAINED FROM, EXCHANGED WITH THE ORGANIZATION ABOVE, (AGENCY, INSTITUTION, OR INDIVIDUAL), AND IS TO BE ACCOMPANIED BY A STATEMENT PROHIBITING REDISCLOSURE. THIS CONSENT MAY BE REVOKED IN WRITING AT ANY TIME. REVOCATION SHALL CAUSE RELEASE OF INFORMATION TO CEASE IMMEDIATELY EXCEPT THE EXTENT THE PROGRAM OR PERSON WHO IS TO MAKE THE DISCLOSURE HAS ALREADY ACTED IN RELIANCE ON IT. IF YOU ARE RECEIVING MENTAL HEALTH SERVICES YOUR CONSENT MUST BE REVOKED IN WRITING. THE AUTHORIZATION WILL REMAIN IN EFFECT FOR **365** DAYS FROM THE DATE OF SIGNATURE, UNLESS REVOKED. RELEASE WILL EXPIRE UPON TERMINATION OF SERVICES. **AFTER TERMINATION, REQUESTS FOR RELEASE OR EXCHANGE MUST BE AUTHORIZED BY A NEW FORM. RECIPIENTS OF INFORMATION ARE PROHIBITED FROM REDISCLOSURE WITHOUT MY SPECIFIC AUTHORIZATION. HOWEVER, SOME PARTIES TO WHOM INFORMATION IS DISCLOSED ARE GOVERNED BY DIFFERENT RULES REGUARDING CONFIDENTIALITY SO WE CANNOT GUARANTEE COMPLIANCE WITH CONFIDENTIALITY RULES TO WHICH THIS AGENCY ADHERES.** A PHOTOCOPY OF THIS FORM IS CONSIDERED TO BE EQUIVALENT TO THE ORIGINAL.

CLIENT SIGNATURE _____ **DATE** _____

WITNESS _____ **DATE** _____

PARENT/LEGAL GUARDIAN SIGNATURE _____ **DATE** _____

I revoke this release on Date _____ **Signature** _____

OFFICE USE ONLY:
_____ **SEND INFORMATION TO IDENTIFIED CONTACT** _____ **SCAN TO CHART FOR REFERENCE**
_____ **REQUEST INFORMATION FROM IDENTIFIED CONTACT**

Rev. 2/2020