AUTHORIZATION FOR RELEASE OF INFORMATION

Charges for this request may apply

I hereby grant my permission for release of the following information relating to my care between the parties named here. I am aware that once this information is released to another party it may no longer be protected.

Homefull	AND	_____
2621 Dryden Rd, Suite 302		_____
Moraine, OH 45439		_____
Phone: 937-293-1945		_____

This information is to be: ☐ Mailed ☐ Emailed ☐ Picked Up ☐ Phoned ☐ Faxed

The purpose of this request is for:

☐ Continuity of care ☐ Legal Matter ☐ Insurance Claim ☐ Personal ☐ Other: _____

_____	_____	_____
Name (Head of Household)	Date of Birth	SSN
_____		_____
Address		Telephone Number

Date of treatments: _____

☐ Final Diagnosis	☐ Medications Prescribed	☐ Drug/Alcohol Use Disorder Treatment
☐ Discharge Summary	☐ Mental Health Assessment	☐ History
☐ Mental Health History	☐ Physical Exam	☐ Psychological Assessment
☐ Emergency Room Treatment	☐ Consultation	☐ Physician Orders
☐ Drug/Alcohol Use Assessment	☐ Social History	☐ Treatment / Service History
☐ Ind. Education Plan (IEP)	☐ Transitional Plans	☐ Disability Information
☐ Vocational Assessment	☐ Other (specify) _____	

This information has been disclosed to you from records protected by federal confidentiality rules. 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 42CFR 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 information to criminally investigate or prosecute any alcohol or drug abuse client. I understand that this authorization may be revoked at any time in writing, except to the extent that the program or person who is to make the disclosure has already acted in reliance on it. This authorization will remain in effect for 365 days after I sign and date the form below or until _____. I understand this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand that I may revoke my authorization at any time and for any reason. I understand that I can lengthen or shorten the authorization period by date, event, or condition.

This authorization expires on: _____.

_____	_____
Client Signature	Date
_____	_____
Signature of Authorized Representative	Date
_____	_____
Witness/ Agency Representative	Date

If the above signature is not of the client, explain and obtain verification: _____

Extended Date from: _____ to _____ Signature: _____ Date: _____

Revocation must be submitted in writing. If applicable, date of revocation: _____