ONE Health Ohio

Consent to Release and /or Receive Information Under
Title 42, Part 2, Code of Federal Regulations

I, _____authorize the exchange of confidential information between
(Please Print Your Name)

ONE Health Ohio and _____
(Please Print)

In the following areas: (Please print yes or no in spaces)

_____Comprehensive Assessment _____Progress Notes _____Medications

_____Treatment Plan _____Discharge Summary _____Urine Drug Screen

_____Attendance Dates _____Lab Results _____Billing

For the following purpose: _____
(Please Print)

Please provide the name, address, phone number and fax number of the person you are granting ONE Health Ohio to release and discuss information with. (Please print)

Name:_____

Address:_____

Phone Number:_____Fax Number:_____

I understand and authorize that information contained in the record to be released may include, but is not limited to, alcohol and drug abuse diagnosis and information, sexually transmitted disease, behavioral/mental health, psychological and psychiatric conditions, human immunodeficiency virus (HIV) testing/diagnosis, acquired immunodeficiency syndrome (AIDS) testing/diagnosis and AID related conditions.

I understand that my medical records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that this consent may be revoked in writing by me at any time except to the extent that action has already been taken in accordance with this original consent. If no early revocation occurs, this consent will terminate one year from the date of authorization as noted below.

_____ _____ _____
Client Signature Date of Birth Date Signed

_____ _____
Staff Signature Date Signed

I hereby revoke the above consent effective: Date:_____ Time:_____

_____ _____ _____
Client Signature Date of Birth Date Signed

_____ _____
Staff Signature Date Signed