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

ONE Health Ohio at: (select one**)**
☐ **Youngstown Community Health Center:** 726 Wick Ave, Youngstown, OH 44505 | 330-747-9551 | Fax 330-747-2740
☐ **Warren West Community Health Center:** 716 Tod Ave. SW, Warren OH 44485 | 330-373-0222 | Fax 330-393-3764
☐ **Lloyd McCoy Community Health Center:** 1977 Niles Rd., Warren, OH 44484 | 330-393-6446 | Fax 330-369-1580
☐ **Good Samaritan Community Health Center:** 1390 South Arch Ave., Alliance, OH 44601 | 330-821-3961 | Fax 330-821-0232
☐ **Kidz 1st Pediatrics:** 1821 E. Market St., Warren, OH 44483 | 330-392-7000 | Fax 330-392-0864
☐ **Falls Family Care:** 175 E. Broad St., Newton Falls, OH 44444 | 330-872-2010 | Fax 330-872-4309
☐ **Premier Care Pediatrics:** 2642 State Rt. 5 (Medical Building C), Cortland, OH 44410 | 330-841-5500 | Fax 330-841-5510
☐ **Rise Recovery (Youngstown):** 3132 Belmont Ave., Youngstown, OH 44505|844-652-8219|Fax 866-793-5728
☐ **RISE Recovery (Warren):** 1977 Niles Rd., Warren, OH 44484 |844-652-8219|Fax 866-793-5728
☐ **RISE Recovery (Alliance):** 1390 South Arch Ave., Alliance, OH 44601 |844-652-8219|Fax 866-793-5728
☐ **RISE Recovery (Newton Falls):** 175 E. Broad St., Newton Falls, OH 44444 |844-652-8219|Fax 866-793-5728

I, _____ Patient's Date of Birth _____
Printed Patient's Name EXACTLY as recorded in the Electronic Health Record — MM/DD/YYYY

authorize the exchange of confidential information between ONE Health Ohio and:

_____
Printed Name of the Organization Authorized to receive or release the information.

I am requesting medical records:

for dates of service: from _____ to _____

for the following purpose: _____
Print

e.g., coordination of care, transfer of care

_____ All my substance abuse records. **PRINT YES**

Specific types of records **PRINT YES** next to the to the record be released, **PRINT NO** next to the records not to be released.

_____	Medications	_____	Lab Results	_____	Toxicology Results
_____	Discharge Summary	_____	Insurance Information	_____	Demographic Information
_____	Medical Progress Notes	_____	Alcohol/Drug Abuse Progress Notes	_____	Psychiatric Progress Notes
_____	Medical Assessments	_____	Alcohol/Drug Abuse Assessments	_____	Psychiatric Assessments
_____	Substance Use History	_____	Alcohol/Drug Abuse Attendance	_____	Psychiatric Attendance Dates
_____	Medical Treatment Plans	_____	Alcohol/Drug Abuse Treatment Plans	_____	Psychiatric Treatment Plans
_____	Behavioral Health Progress Notes			_____	Behavioral Health Treatment Plans
_____	Behavioral Health Assessments			_____	Behavioral Health Attendance Dates

I am requesting my records not be shared: _____
Patient printed name.

_____ _____
Patient signature — *Date signed.*

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 be advised:** ***Failure to provide an accurate method of contact will result in your request being denied.***

Name: _____
Print

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 AIDS 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.

_____ _____ _____
Patient Signature Date of Birth Date Signed

_____
Staff Printed Name

_____ _____
Staff Signature Date Signed

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

_____ _____ _____
Patient Signature Date of Birth Date Signed

_____
Staff Printed Name

_____ _____
Staff Signature Date Signed