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

1. Authorization: I, ____,
   hereby voluntarily authorize the confidential disclosure of information from my health record

2. Information to be Disclosed By:	3. Information to be Disclosed To:
Name of Facility/Organization:	Name of Facility/Organization
Address:	Address:
City/State:	City/State:
Phone Number:	Phone Number:
Fax Number:	Fax Number:

4. The Purpose for Disclosure Is: (Select One)

	Continuity of Care		Referral		Transfer of Care		School		Disability
	Insurance		Personal Use		Legal		Other:		

5. Dates of Service for Disclosure:
   ____ All Dates of Service or Specific Dates of Service from: ___________________ to ____________________.

6. Information to be Disclosed from My Health Record Is: (Write Yes or No)
   ___ Demographic Information. ____Insurance Information ____ Billing Information
   ___ Substance Use Records ____ Medical Records ____ Behavioral Health Records
   ___ Psychotherapy Records ____ Lab/Toxicology Studies ___ Medical/Diagnostic Studies
   ___ Medications ____ Substance Use History ___ Billing

7. Authorization:
   I understand that I may revoke this authorization in writing at any time to the Medical Records Department or in person when on site, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a shorter expiration date or event is stated.
   Specific Date for New Expiration: ____

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 treatment, payment, enrollment or eligibility cannot/will not be conditioned on my signing this authorization, however if allowed by state law there may be limited access to treatment if unable to provide needed information for appropriate care

______________________________ ____________ ____________
Patient Signature | Date of Birth | Date Signed

____
Staff Printed Name

______________________________ ____________
Staff Signature | Date Signed

Patient received a copy of this disclosure: __________ (Staff initials) Patient refused a copy of this disclosure: __________ (Staff initials)

This Section for Revocation Only

I hereby revoke the above consent effective: Date: ______________________ Time: ____________________

______________________________ ____________ ____________
Patient Signature | Date of Birth | Date Signed

____
Staff Printed Name

______________________________ ____________
Staff Signature | Date Signed

Patient received a copy of this revocation: _________ (Staff initials) Patient refused a copy of this revocation: __________ (Staff initials)

For clients receiving addiction services treatment, the either of the following statements: (a) "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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see 42 CFR 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 42 CFR 2.65."; or (b) "42 CFR part 2 prohibits unauthorized disclosure of these records."