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. I, _____, hereby voluntarily authorize the confidential disclosure of information from my health record

Failure to provide accurate information may result in your request being delayed or not processed

2. Information to be **Released** from:	3. Information to be **Received** by
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 release of records: (Select all that apply)

☐ Continuity of Care ☐ Transfer of Care ☐ Referral ☐ School ☐ Disability

☐ Insurance ☐ Personal Use ☐ Legal ☐ Other _____

5. Dates of service for release of records: from _____ to _____ or ____ all dates of service

6. I understand and authorize that information contained in the record to be released may include, but is not limited to, alcohol and drug abuse / misuse 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.

The information to be **released** includes the following (**mark all that apply**)

☐ Substance Abuse ☐ Insurance ☐ Billing Records
☐ Medical Records ☐ Behavioral Health Records ☐ Psychotherapy Records
☐ Medications ☐ Medical/Diagnostic Studies ☐ Lab/Toxicology Studies
☐ Dental Records ☐ Other: _____ ☐ Progress Notes

Probation/Parole: Additional progress information requested after initial disclosure ____ Weeks ____ Months

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. This authorization will terminate one year from the date of my signature unless a shorter expiration date or revocation is stated. Expiration Date: _____

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: _____ Patient refused a copy of this disclosure: _____

Staff initials | 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: _____Patient refused a copy of this revocation: _____

Staff initials | Staff initials

For clients receiving addiction services treatment, 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."

ONE HEATH OHIO
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

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Address:	Address:
City/State:	City/State:
Phone Number:	Phone Number:
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4. The purpose for release of records: (Select One)

☐ Continuity of Care ☐ Transfer of Care ☐ Referral ☐ School ☐ Disability

☐ Insurance ☐ Personal Use ☐ Legal ☐ Other _____

5. Dates of service for release of records from: _____ to _____ or ____ all dates of service

6. The information to be **released** includes the following (**mark all that apply**)

☐ Demographics ☐ Insurance ☐ Billing Records

☐ Medical Records ☐ Behavioral Health Records ☐ Psychotherapy Records

☐ Medications ☐ Medical/Diagnostic Studies ☐ Lab/Toxicology Studies

☐ Dental Records ☐ Other:_____ ☐ Progress Notes

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_____ _____ _____
Patient Signature Date of Birth Date Signed

_____
Staff Printed Name

_____ _____
Staff Signature Date Signed

Patient received a copy of this disclosure: _____ Patient refused a copy of this disclosure: _____
Staff initials 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: _____Patient refused a copy of this revocation: _____
Staff initials Staff initials
