Rescue Mental Health Services
3350 Collingwood Boulevard
Toledo, Ohio 43610 Phone (419) 255-9585
Fax (419) 324-0234

AUTHORIZATION TO DISCLOSE INFORMATION

Client's Name _____
(First) (Middle Initial) (Last)

Date of Birth _____ Social Security # _____

In accordance with Federal Regulation 42 CFR, Part 2 (**Prohibition Against Re-Disclosure**),

"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 this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client."

I hereby authorize Rescue Mental Health Services to ☐ **Obtain Information from,** ☐ **Disclose Information to,** or ☐ **Exchange Information** with the Authorized Organization or Individual noted below: (Significant other may include spouse, family member, case manager, friend, etc.)

_____
Name of Authorized Organization or Individual to Whom Disclosure is to be Made

Street Address _____

City/State/Zip Code _____ Fax # _____

The **Information to be Disclosed** (check specific reports or note types of information):

☐ Diagnostic Assessment ☐ Treatment Plan ☐ Progress Notes ☐ Discharge Summary ☐ Aftercare Instructions
☐ Psychiatric Assessment ☐ History of Illness ☐ Health Questionnaire ☐ Ohio Outcomes

Other _____

Admission Period: ☐ Information covering the most recent admission ☐ Information covering the last three months
And/or ☐ for the contacts covering the dates from _____ to _____

Specific Purpose for this Disclosure is: ☐ to Coordinate Treatment ☐ for Further Care/On-going Treatment ☐ for a Personal Record ☐ Other (please specify) _____

I release Rescue Mental Health Services and _____ (above named facility) of any legal liability that may arise from the release and/or exchange of the indicated information.

I understand that this authorization will automatically expire 90 days after the signed date below unless otherwise indicated.

Date and Reason of earlier expiration _____

Neither Rescue Mental Health Services nor the other above named facility may release the information indicated above to any other individual or facility without my express written permission.

Date: _____ Signed: _____ Relationship:_____
I hereby Authorize Information Disclosure. (Self, Guardian, Parent, etc.)

Witness: _____

Revocation: I also understand that this Authorization for Disclosure may be revoked by me at any time except to the extent that RMHS has already acted upon the reliance of this signed authorization. The revocation must be signed and dated by myself unless this is a disclosure concerning drug and/or alcohol information. My drug and/or alcohol revocation may be verbal.

Date: _____ Signed:_____ Relationship:_____
I hereby revoke my consent in writing. (Self, Guardian, Parent, etc.)

Date: _____ Time: _____ ☐ **Authorization was verbally revoked.**

Witness: _____