☐ Send ☐ File Only ☐ Request Documents

CHILD AND ADOLESCENT BEHAVIORAL HEALTH
AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____/_____
(Parent/Guardian/Client if age 18 or older)
hereby grant my permission to CHILD AND ADOLESCENT BEHAVIORAL HEALTH and any of its agents to

☐ Release (R)
☐ Obtain (O)
☐ Verbal Exchange (VE)

any information indicated below regarding: (Client)_____; DOB:_____
as part of CHILD AND ADOLESCENT BEHAVIORAL HEALTH's professional relations with:

NAME AND ADDRESS OF PERSON OR ORGANIZATION

Name: _____

Address: _____

City/State/Zip: _____

Phone/Fax #: _____

For the sole purpose of: ☐ Continuity of care ☐ Personal records
☐ Other (please specify): _____

Date(s) of service: _____.

Please indicate the date range (i.e., 2005-2007) of documents/services to be included in this release. Do not indicate a single date of service unless you are only releasing information for a specific day.

I hereby grant permission for the exchange of information checked below between CHILD AND ADOLESCENT BEHAVIORAL HEALTH and the agency or individual indicated above.

Clinical Records/Information:

☐ Diagnostic Assessment	☐R	☐O	☐VE
☐ Psychological Evaluation	☐R	☐O	☐VE
☐ ADHD Assessment	☐R	☐O	☐VE
☐ Discharge Summary	☐R	☐O	☐VE
☐ Treatment Plan	☐R	☐O	☐VE
☐ Reason for Referral	☐R	☐O	☐VE
☐ Treatment Compliance	☐R	☐O	☐VE
☐ Recommendations	☐R	☐O	☐VE
☐ Restriction(s)	☐R	☐O	☐VE
☐ Outcomes Data	☐R	☐O	☐VE
☐ Client name for purpose of program evaluation	☐R	☐O	☐VE
☐ Emergency	☐R	☐O	☐VE

Medical Records/Information:

☐ Psychiatric Evaluation	☐R	☐O	☐VE
☐ Psychotropic Medication History w/Dosages	☐R	☐O	☐VE
☐ Other Medication History w/Dosages-Rational	☐R	☐O	☐VE
☐ Lab tests and results	☐R	☐O	☐VE
☐ History of past psychiatric hospitalizations	☐R	☐O	☐VE
☐ History of treatment for sleep and/or eating problems	☐R	☐O	☐VE
☐ History of treatment for PT, OT, Speech	☐R	☐O	☐VE
☐ Letter of transfer to PCP	☐R	☐O	☐VE
☐ Current contact information	☐R	☐O	☐VE
☐ Other (specify): _____	☐R	☐O	☐VE

School Records/Information:

☐ Most recent ETR	☐R	☐O	☐VE
☐ Attendance records	☐R	☐O	☐VE
☐ 504 Plan / other special services	☐R	☐O	☐VE
☐ Grades for current school year	☐R	☐O	☐VE
☐ Permission to be seen at school	☐R	☐O	☐VE
☐ Most recent IEP	☐R	☐O	☐VE
☐ Behavioral/Discipline incidents	☐R	☐O	☐VE
☐ Proficiency and standardized testing results	☐R	☐O	☐VE
☐ Classroom Assessment	☐R	☐O	☐VE

I hereby state that I have had read to me and fully understand the above statements as they apply to me and do herein expressly consent to the disclosure of the above stated information for the purpose or need to the extent stated above. I further understand that I may revoke this consent at any time, except when disclosure has already been made. I am aware that this information is disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit either party from asking any further disclosures of information shared to any person/organizations not specifically listed on this form without written permission. A general authorization for the release of medical or other information IS NOT sufficient for this purpose.

I understand that if the person or entity that receives the requested information is not a health care provider or health plan covered by federal regulation, the described information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand this authorization is voluntary and Child and Adolescent Behavioral Health will not condition treatment, payment, enrollment or eligibility for benefits on this authorization.

I UNDERSTAND THAT THE CLINICAL RECORD MAY CONTAIN INFORMATION REGARDING PSYCHIATRIC CONDITIONS, DRUG/ALCOHOL ABUSE, AND MAY CONTAIN HIV TEST RESULTS, A DIAGNOSIS OF AIDS OR AN AIDS-RELATED CONDITION, AND EXPRESSLY CONSENT TO THE RELEASE OF ANY SUCH INFORMATION CONTAINED IN THE RECORDS DESIGNATED ABOVE. _____I do <u>not</u> want this information released.

_____ ***I have received a copy of this release.*** _____***I was offered a copy of this release and I decline.***

A copy of this release will be considered as valid as the original and will expire in
____180 days, ____365 days, or _____ days (any other number of days, but not to exceed 1 year from the date it is signed).

The parent/guardian/client, if age 18 or older, may shorten or lengthen the authorization period, not to exceed one year. If other than 180 days, the parent/guardian/client (if 18 or older) must sign _____/_____.

The release may be revoked by parent/guardian/client, if age 18 or older, by signing and dating where indicated.

Client's Signature: _____ Date: _____
(required if 18 or older)

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Relationship of above Client: _____ Date: _____

Witness Signature (required): _____ Date: _____

I revoke this release of information: _____ Date: _____

Witness: _____ Date: _____

Send information to:

☐ Child and Adolescent
Canton Office
919 2nd St. NE
Canton, OH 44704
330-454-7917 (phone) 330-452-8860 (fax)

☐ Child and Adolescent
Belden Center Office
4641 Fulton Rd. NW
Canton, OH 44718
330-433-6075 (phone) 330-494-0299 (fax)

☐ Child and Adolescent
Alliance Office
1207 W. State St., Suite G
Alliance, OH 44601
330-823-5335 (phone) 330-823-9177 (fax)

☐ Child and Adolescent
Plain Community Office
1811 Schneider St. N.E., Door 6
Canton, Ohio 44721
330-470-4061 (phone) 330-470-4083 (fax)