HOPE419

Psychiatry and Counseling
1221 South Trimble Road, Mansfield, Ohio
Phone and Fax: (419) 951 2020

Hope419, LLC Authorization for Release of Information

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

I authorize Hope 419 to exchange information with:

Name: _____

Address: _____

Phone: _____ Fax: _____

PURPOSE OF THIS REQUEST: ☐ **Healthcare** ☐ **Insurance Coverage** ☐ **Personal** ☐ **Other**

TYPE OF RECORDS AUTHORIZED:

- ❑ **Psychiatric/Psychological Evaluation and/or Treatment**
- ❑ **Drug/Alcohol Evaluation and/or Treatment**

SPECIFIC INFORMATION AUTHORIZED: (circle one or more as appropriate)

ALL INFORMATION CAN/SHOULD BE EXCHANGED AS NECESSARY

Assessments	Progress Notes	Laboratory TestResults
Diagnostic Impression	Discharge Summary	Treatment Plans
Treatment Summary	Other: (please describe)_____	

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire when I am no longer receiving services from Hope 419.

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a *written* request to Providers for Healthy Living.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

Signature of Patient or Representative: _____ Date:_____

Printed Name of Person Signing Form:_____

Relationship to Patient (*if requester is not the patient)*: Parent Legal Guardian Other: _____