**Family Solutions of Ohio VALID UNTIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AUTHORIZATION FOR EXCHANGE OF INFORMATION REVOKED EFFECTIVE: \_\_\_\_\_\_\_\_\_**

I hereby authorize the use and disclosure of my individually identifiable Protected Health Information (PHI) as described below. I understand that if the recipient of my PHI is not a covered entity, the released information may no longer be protected by federal and state privacy laws and regulations. I understand that other laws, however, may prohibit or limit re-disclosure (e.g. 42 CFR Part 2) and FSO is required to inform the recipient of this prohibition. This authorization is voluntary.

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| Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel. No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Family Solutions of Ohio to exchange information with:  Name of Person or Agency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Tel. No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax No. \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client if a person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| INFORMATION TO BE DISCLOSED: ***Client must initial all that apply*** |
| **Assessment & Diagnosis**\*Mental Health \_\_\_ \*Alcohol & Drug \_\_\_\*Blended MH & AoD \_\_\_\*Psychiatric Eval \_\_\_\_**Diagnosis (es) only \_\_\_\_****Financial Information \_\_\_\_****Attendance \_\_\_\_****Treatment Plan(s)****and Reviews \_\_\_\_** | **Service/Progress Notes**\*Mental Health Txt. \_\_\_\_\*Alcohol & Drug Txt. \_\_\_\_\*Blended MH & AoD \_\_\_\_**Crisis Services \_\_\_\_****Medications \_\_\_\_\_****Transition & Referral \_\_\_\_\_****Discharge Summary****\***MH \_\_\_\_\*AoD \_\_\_\_\*Blended MH & AoD \_\_\_\_ | **Drug Screen/UDS Report \_\_\_\_****HIV/AIDS Test Result \_\_\_\_****Pregnancy Test Result \_\_\_\_****Pre-natal care \_\_\_\_****Demographic Info Only: \_\_\_\_\_****OTHERS:****\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_****\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_** |

PURPOSE OF DISCLOSURE: ***Client must initial all that apply***

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| Coordination of Care \_\_\_\_\_Link to Needed Resources \_\_\_\_Verification of Attendance \_\_\_\_ | Court Proceedings \_\_\_\_\_Verification of Benefits \_\_\_\_\_Review of Disability \_\_\_\_\_ | **OTHER:****\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_****\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_** |
| DATE RANGE OF INFORMATION TO BE DISCLOSED: **Beginning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

 1 of 2 pages

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| Name: Record No.  | Page 2 of 2 |
| 1. I understand that this authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (180 days from the date of my signature below unless otherwise specified).
2. I understand that except to the extent that action has been taken upon my authorization, I may withdraw/revoke this authorization at any time by WRITTEN notification to FSO or signing the revocation section of this form.
3. I understand that FSO reserves the right to withhold information authorized to be released from the record that is determined to create a substantial risk of physical harm to me or others or will make effective treatment impossible. In such instance, I will be provided notification, explanation, and an opportunity to meet with the appropriate FSO staff to review the record. The final determination will be made by designated FSO Clinical Compliance Team of FSO.
4. I understand that documents not authored by this Agency cannot be re-released by FSO but must be secured from the author of the document.
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**SIGNING THIS FORM IS VOLUNTARY**

* **I understand that I may refuse to sign this authorization form. FSO may not condition my treatment on whether I sign this form.**
* **I understand my right to receive a copy of this form.**

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| X**Signature of Client**Signature of the Minor Client is REQUIRED at all times if AoD Services have been provided. | Date |
|  X**Signature of Legal Guardian if Client is a Minor** | Date |
|  X**Signature of Witness** | Date |

 **REVOCATION OF THIS FORM:**  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby revoke my authorization above. Further exchange of information shall cease immediately.

(This authorization is subject to revocation at any time except to the extent FSO has already acted in reliance to it.)

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| X**Signature of Client**Signature of the Minor Client is REQUIRED at all times if AoD Services have been provided.  | Date |
| X**Signature of Legal Guardian if Client is a Minor** | Date |
| X**Signature of Witness:** | Date |

**NOTICE TO RECIPIENT OF FSO INFORMATION**: Federal rules restrict any use of the information obtained from FSO to criminally investigate or prosecute any alcohol or drug abuse of FSO client. 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 re-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 is NOT sufficient for this purpose. This applies to every disclosure under this authorization.

Family Solutions of Ohio, Authorization for Exchange of Information FS Form ROI Exchange