333 Conover Dr, Stes B and D, Franklin, OH 45005
231 N Breiel Blvd, Middletown, OH 45042
2020 Sherman Ave, Ste 202, Norwood, OH 45212
3420 Atrium Blvd, Ste 102, Franklin, OH 45005
513-318-1188 Office | 513-318-1189 Fax

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Last Name:	First Name:	MI:
Date of Birth:	Social Security Number (optional):	
Address:		
City:	State:	Zip:

My health information may be released to:

Name: _____

Address: _____

_____

_____

Phone: _____ **Fax:** _____

My health information may be received from:

Name: _____

Address: _____

_____

_____

Phone: _____ **Fax:** _____

Description of information being disclosed (what kind of information and how much information) for the following date(s) of service:

❒Complete Health Record	❒Current Diagnoses	❒Laboratory Reports
❒Intake/Clinical Evaluation(s)	❒Medication Order Sheet(s)	❒ Operative Reports
❒ Progress Note(s)	❒Discharge Summary	❒History and Physical Consultation
❒Radiological Reports	❒Pathology Reports	❒Emergency Room Treatment
❒Psychiatric Evaluation(s)	❒Treatment Plan(s)	❒ Other: _____

Purpose of the Disclosure: (Example: "At the request of the patient"): _____

_____

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Expiration: This Authorization expires within ninety (90) days of signature.

I understand that:

1. This Authorization extends to all, or any part of, the records designated above, which may include records that indicate that I am or have been in treatment for a substance use disorder.
2. I may revoke this Authorization at any time by providing written revocation to Centerpoint Health. I understand that I may revoke this Authorization, except to the extent that action has already been taken in reliance on this Authorization.
3. Signing this Authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign this Authorization.
4. The information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected upon its release to the recipient in accordance with HIPAA.
5. I may have the right to inspect or copy the health information to be used or disclosed pursuant to this Authorization.

Signatures: I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient (or Patient's Representative):	Date:
Print Name of Patient (or Patient's Representative):	

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

❒ Power of Attorney	❒Legal Guardian	❒ Surrogate Decision-Maker
❒ Executor or Personal Representative	❒ Parent	❒ Other: _____

For internal use only: Records were delivered by: ❒Fax ❒Mail ❒Personal Delivery Date: _____

**** TO THE RECIPIENT: This information has been disclosed to you from confidential records protected by Federal Law. If you have received this information in error, please notify Centerpoint Health immediately**.

4892-9666-8391, v. 1