AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____ , authorize the use or disclosure of my
Client's Full Name   Date of Birth

individually identifiable health information as described below for the following purpose(s): enroll me in the Cuyahoga County Behavioral Health Services Plan through the MACSIS Claims System, determine my eligibility for public funds and pay my treatment provider for services;

Persons/organizations **providing** the information:	Person/organizations **receiving** the information:
______________________	ADASBCC
______________________	ODADAS
______________________	ODJFS
______________________	CCCMHB
______________________	ODMH

INFORMATION BEING DISCLOSED IN DETAIL:

a. Check and initial information being shared:

☐ ____ Identifying information: Name, birth date, sex, race, address and telephone number
☐ ____ Social security number
☐ ____ Demographic Information-BH Module
☐ ____ Medical records including:

____

________________ for the dates from _____________ through ______________________

☐ ____ Social History including:
☐ ____ Financial information necessary to establish eligibility for public assistance including, but not limited to, pay stubs, W-2 forms and tax returns, and other financial information.
☐ ____ Other information:

b. I understand that the information to be released includes: (initial appropriate boxes)

☐ ____ AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment;
☐ ____ HIV test results;
☐ ____ Diagnoses and/or treatment relating to other communicable diseases;
☐ ____ Diagnoses and/or treatment for alcohol and/or drug abuse;
☐ ____ Except as limited as follows: ____

Cancelling this Authorization will become effective the date of the cancellation and will apply to that day forward and not to information already shared.

This Release is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it. I understand that I may cancel this Authorization at any time by providing a dated and written statement with my signature to: __________________________ (entity disclosing info).

I understand that if I have authorized the ____________________(entity disclosing info) to disclose my protected health information to persons who are not required by Federal or State law to keep the information confidential, these persons who are receiving the records may disclose my protected health information to others without my consent or authorization.

I understand that the Board cannot deny me treatment if I do not sign the authorization unless the health plan that pays for my treatment requires authorization prior to enrollment or the purpose of the Board's health care activities is to create requested health information.

EXPIRATION

This consent will expire on:

365 days after discharge

____

(Insert date or event of expiration: if mental health records, cannot exceed limits set forth below)

If information being released includes mental health records, this authorization will automatically expire: (check applicable box)

☐ No later than 90 days after signing for mental health care

☐ No later than 180 days after signing for ongoing mental health care

☐ At the end of an approved research study

NOTICE

1. If the records released include information of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:

   PROHIBITION ON REDISCLOSURE OR INFORMATION CONCERNING CLIENTS IN ALCOHOL OR DRUG ABUSE TREATMENT.

   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 patient. Drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 and 164. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.)

2. If the records released include information of an HIV-related diagnosis or test results, the following statement applies: This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for the purpose of the release of HIV test results or diagnoses.

A copy of this authorization shall have the same force and effect as the original. ☐ Copy given to client

____ ____________________

Signature of client Date

Or

____ ____________________

Signature of client's personal representative Date

Explanation of representative's authority to act on behalf of client: ________________________________

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