

MID-OHIO PSYCHOLOGICAL SERVICES, INC.

624 East Main Street
Lancaster, Ohio 43130

Voice (740) 687-0042 / Fax (740) 687-6677

RELEASE OF INFORMATION

Client Name:		Date:	
Address:		Date of Birth:	
		Social Security #	
Guardian Name:		Guardian Address:	

I hereby authorize Mid-Ohio Psychological Services, Inc. and _____ to communicate about the following protected information from my clinical record (those checked):

To be released by Mid-Ohio Psychological Services, Inc.

<input type="checkbox"/> Attendance in Counseling	<input type="checkbox"/> Progress in Treatment	<input type="checkbox"/> Diagnosis
<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Psycho-Social History	<input type="checkbox"/> Treatment Recommendations
<input type="checkbox"/> Alcohol/Drug information	<input type="checkbox"/> Other (specify)	

To be released to Mid-Ohio Psychological Services, Inc.

<input type="checkbox"/> Legal Documents	<input type="checkbox"/> Work/School Attendance	<input type="checkbox"/> Medical History/Treatment
<input type="checkbox"/> Case Plan	<input type="checkbox"/> Work/School Performance	<input type="checkbox"/> Psychiatric/Psychological History
<input type="checkbox"/> Investigation Info	<input type="checkbox"/> Vocational Evaluation	<input type="checkbox"/> Summary of Treatment
<input type="checkbox"/> Treatment Recommendations	<input type="checkbox"/> IEP/Multi-Factored Evaluation.	
<input type="checkbox"/> H&P Report	<input type="checkbox"/> Discharge Report	<input type="checkbox"/> AOD Treatment./History
<input type="checkbox"/> Discovery Materials	<input type="checkbox"/> Other (specify)	

The purpose of this exchange of information is to:

- Conduct a formal evaluation for: _____
- Facilitate treatment

The information exchanged should reflect material collected:

- In the last six months
- In the last year
- In the last five years
- Since first contact with the client

I may revoke my consent to release this information at any time except to the extent that action will have been taken or information released prior to the revocation of my consent. I understand that treatment is generally not a condition of my signing an authorization to release information. This authorization form is valid until six months from application date or _____ (if less than six months). Generally, this information may not be re-released, but I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule. This information has been disclosed from records whose confidentiality is protected by Ohio Revised Code 5122.31, and Ohio Department of Mental Health Rules for Clinical Records 5119:1-7-11.

This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part II. A general authorization for the release of medical or other information is not sufficient for this purpose. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.

	Signature:	Name(print):	Date:	Relationship
Client/Guardian				Client/Guardian
Witness/Guardian				Witness
Requesting Staff				Therapist