Access Counseling Services, LLC (rev. 10/12)

AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT NAME:_____ **DATE OF BIRTH:** _____

I hereby authorize:

Access Counseling Services Name of individual, institution	to exchange info with	_____ Name of individual, institution
4464 S. Dixie Hwy. Address		_____ Address
Middletown, Ohio 45005 City & state		_____ City & state
Phone: 513-649-8008 Fax: 513-649-8004		Phone: _____ Fax: _____

I authorize the following information to be released:

- ❑ Diagnostic Assessment
- ❑ Urine Screen/ Lab Results
- ❑ Discharge Summary
- ❑ Progress Notes
- ❑ Treatment Plan
- ❑ Other (specify): _____
- ❑ Consultation
- ❑ Other (specify): _____

Amount of Information to be disclosed: (mark appropriate boxes)

- ❑ information covering the previous three months
- ❑ information covering the most recent admission
- ❑ other amount of information (specify) _____

This authorization includes release of records relating to: (mark appropriate boxes)

- ❑ Diagnoses and/or treatment for alcohol and/or drug abuse
- ❑ HIV test results
- ❑ AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment
- ❑ Diagnoses and/or treatment relating to other communicable diseases

Indicate here any additional exceptions or exclusions, if any, to information released:

This authorization for use/disclosure is for the following purpose:

My refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, or enrollment in a health plan. This authorization will remain in effect for 90/180 days (circle one) unless an earlier date or condition/event is specified here: _____.

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here: _____.

NOTE:" This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules (ORC 5122.31, 42 CFR Part 2, and/or ORC 3701.243) 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 information to criminally investigate or prosecute any alcohol or drug abuse client."

Signature of Client/Guardian/ Personal Representative:	**Date Signed:**	**Print Name:**
Signature of Witness:	**Date Signed:**	**Print Name:**

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To Revoke

I understand that I have the right to revoke this authorization, at any time by submitting a written request to revoke authorization, and that the revocation will be effective except to the extent that Access Counseling Services, LLC has already taken action in reliance on my authorization.

I hereby revoke this authorization effective as of: _____.

Signature of Client/Guardian/ Personal Representative:	**Date Signed:**	**Print Name:**