SOLUTIONS COMMUNITY COUNSELING AND RECOVERY CENTERS

CACWC
100 Campus Loop Road
Franklin, OH 45005
513-261-6033 (FAX# 261-6032)

204 Cook Road
Lebanon, OH 45036
513-695-1357 (FAX# 695-2952)

975 Fujitec Drive
Lebanon, OH 45036
513-228-7800 (FAX# 228-7847)

201 Reading Road
Mason, OH 45040
513-398-2551 (FAX# 459-7300)

50 Greenwood Lane
Springboro, OH 45066
937-746-1154 (FAX# 746-8523)

953 S. South St.
Wilmington, Ohio 45177
937-383-4441 (FAX# 383-2916)

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name _____

Date of Birth _____ **Client Number**_____

If you receive information released with this form the following Federal Law applies directly to you:

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 client.

I AUTHORIZE SOLUTIONS COMMUNITY COUNSELING AND RECOVERY CENTERS, **TO RELEASE TO, OBTAIN FROM, or EXCHANGE WITH** THE ORGANIZATION INDICATED ABOVE CONCERNING TREATMENT OF THE ABOVE NAMED CLIENT. THIS AUTHORIZATION INCLUDES RELEASE OF INFORMATION CONCERNING HIV TESTING OR TREATMENT OF AIDS, AIDS-RELATED CONDITIONS, ALCOHOLISM, DRUG ADDICTION AND/OR PSYCHIATRIC/PSYCHOLOGICAL CONDITIONS.

THE PURPOSE OF THIS RELEASE IS TO:
____Coordinate Treatment ____Assessment Information For Treatment Planning ____Information for Ongoing Treatment
_____Other Purposes (specify):_____

TYPE OF INFORMATION TO BE DISCLOSED: _____**MH only** _____**AOD Only** _____**Both MH and AOD**

_____Discharge Summary	_____Treatment Plan	_____Past Medications	_____Attendance
_____Initial Assessment	_____Treatment Summary	_____Current Medications	_____Progress Notes
_____Psychiatric Evaluation	_____Psychological Evaluation	_____Medical Information	_____Rehabilitation Reports

_____Any Drug and Alcohol Information
_____Any other information pertinent to the treatment of this client (Specify) _____

AMOUNT OF INFORMATION TO BE DISCLOSED:
_____Information covering the previous three months _____Information covering the most recent admission
_____Other amount of Information (Specify) _____

Name of Organization	Warren County CASA
Address	900 Memorial Drive
City/State/Zip	Lebanon OH 45036
Telephone Number	513-695-1356
Attention	

THE ABOVE INFORMATION IS **RELEASED TO, OBTAINED FROM, EXCHANGED WITH** THE ORGANIZATION ABOVE, (AGENCY, INSTITUTION, OR INDIVIDUAL), AND IS TO BE ACCOMPANIED BY A STATEMENT PROHIBITING REDISCLOSURE. THIS CONSENT MAY BE REVOKED IN WRITING AT ANY TIME. REVOCATION SHALL CAUSE RELEASE OF INFORMATION TO CEASE IMMEDIATELY EXCEPT THE EXTENT THE PROGRAM OR PERSON WHO IS TO MAKE THE DISCLOSURE HAS ALREADY ACTED IN RELIANCE ON IT. IF YOU ARE RECEIVING MENTAL HEALTH SERVICES YOUR CONSENT MUST BE REVOKED IN WRITING. THE AUTHORIZATION WILL REMAIN IN EFFECT **365** DAYS FROM THE DATE OF SIGNATURE (IF NO DATE SPECIFIED) OR UNTIL _____ (DATE CANNOT BE LONGER THAN **365** DAYS FROM DATE OF SIGNATURE). THIS RELEASE WILL EXPIRE UPON TERMINATION OF SERVICES. RECIPIENTS OF INFORMATION ARE PROHIBITED FROM REDISCLOSURE WITHOUT MY SPECIFIC AUTHORIZATION. A PHOTOCOPY OF THIS FORM IS CONSIDERED TO BE EQUIVALENT TO THE ORIGINAL.

CLIENT SIGNATURE _____ DATE _____

WITNESS _____ DATE _____

PARENT/LEGAL GUARDIAN SIGNATURE _____ DATE _____

I revoke this release on Date _____ Signature_____ R4/11