UMCH Family Services

AUTHORIZATION FOR RELEASE OF INFORMATION

Request for Information Regarding: _____ _____
(Client Name) (Date of Birth)

Note: All requests for written information are processed by the UMCH HIPAA Privacy Office or Authorized Agency Representatives

I hereby give permission for: ☐ **WRITTEN INFORMATION** ☐ **VERBAL INFORMATION**

Client Records
UMCH Family Services
431 E. Broad Street Columbus, OH 43215
Phone 614-885-5020 Fax 614-885-4058

☐ To release protected health information to ☐ To secure protected health information from

The following agencies/organizations have my permission to give/receive/share any information pertinent to the case for the purposes of continuity of care, case coordination, planning, and funding: (Only agencies involved in the case will be included in this release. Please check the relevant agencies.)

Select	Organization	Select	Organization
☐	Nationwide Children's Hospital/NCH Behavioral Health	☐	Southwestern City Schools
☐	Other: The Ohio State University/Wexner Medical Center/ Harding Hospital	☐	Reynoldsburg City Schools
☐	Franklin County Juvenile Court	☐	Westerville City Schools
☐	Franklin County Children Services	☐	Pickerington Local Schools
☐	Other:	☐	Hilliard City Schools
☐	Other:	☐	Licking Heights Schools
☐	Other:	☐	Columbus City Schools

I authorize the following information to be released:

☐ Diagnostic assessment report
☐ Psychiatric assessments and reports
☐ Report of current functioning
☐ Individualized Service Plan
☐ Termination/discharge summary
☐ Clinician permitted to meet privately on school grounds
☐ Other (specify): _____

Please indicate here exceptions or exclusions, if any, to information being released:

_____

This authorization for use/disclosure is for the following purpose: ☐ Continuity of care ☐ Other (specify)_____

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 effective for the length of treatment unless: an earlier date or condition/event is specified here:

_____

☐ 60 days after case closes at UMCH Family Services

However, I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that UMCH Family Services has already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to UMCH Family Services' Privacy Officer at 431 East Broad Street, Columbus, Ohio, 43215.
NOTE TO ACCOMPANY DISCLOSURES: This information has been disclosed to you from records whose confidentiality is protected from disclosure by State and Federal law. ORC 5122.31, 45 CFR Part 2 and/or ORC 3701.243 prohibit you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, his/her authorized representative, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

_____ _____
(Client Signature – if over the age of 18 or Parent/Guardian) (Printed Name)

_____
(Date)