Recovery Services of Northwest Ohio
511 Perry Street, Defiance, Ohio 43512
Phone (419)782-9920 Fax (419)784-2523

Authorization For Release Of Information

Expires: 1 year from ____
(Date of authorized Client or Guardian's Signature on this form)

Note: All matters relating to alcohol or drug abuse records are considered privileged and confidential and are treated as such by the employees of the program. Information regarding such matters can not be given out without the consent of the client. Section 2.31 of the P. L. 93-282, Part 2, requires the following information:

Recovery Services of Northwest Ohio is hereby granted my permission to exchange information with:

____
(Name of Individual or of the Organization to which the Information is to be made)

(Complete Address): ____
____

____ ______________________
(Full name of the client) **(Date of Birth)**

Purpose or need for disclosure: Please check applicable item(s):

_______ Continuity of care _______ Resolution of legal matters _______ Personal

Specific information to be disclosed: Please have client initial applicable item(s)

_______ Assessment	_______ Behavioral data	_______ Diagnosis & Prognosis	_______ Recommendations
_______ Referrals	_______ Attendance	_______ Progress Notes	_______Progress
_______ Lab Results	_______ Psychiatric Evaluation	_______ Drug Screen Results	_______ Financial & Billing
_______ Emergency Contact	_______ Messages	_______ Case Manager Services	

_______ Other (specify) _________________________________

Amount of information to be disclosed:
Information covering the most recent admission____, Information covering all previous admissions ____
Information covering Other (specify) __DIP PROGRAM____________.

The following rules apply as it relates to the timeline and revocation of the release of information. This release of information naturally expires 1 year from the date of the authorized signature or this release of information expires 6 months post discharge from care if it is not revoked prior to discharge or does not expire naturally within the 1 year time frame from the authorized signature.

I understand that this consent 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. My refusal to sign this authorization will **NOT** affect my ability to obtain treatment, payment, or enrollment in a health plan.

As required by section 2.32(a). Prohibition on Disclosure: "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 the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R.. Part 2. A general authorization for 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 age 12 and up) **(Date)**

______________________________________ _________________
(Signature of Parent or legal guardian of Client) **(Date)**

______________________________________ _________________
(Signature of Staff Witness/Referral Source) **(Date)**

□ Emergency Contact □ Medical Provider □ Referral Source □ Other

For Office Use Only	
Staff Person Releasing Information: ***Agency Authorized Staff Only***	**Date:**

I recognize that I have the right to revoke a Release of Information and am doing so at this time. My signature below signifies that I have acted upon my right. I recognize that any action and communication that has already occurred prior to the revoking of the Release of Information was acted upon with the understanding that the Release of Information was active at that time. Upon signing below, the Release of Information is no longer active and cannot be acted upon by RSNWO staff members. Should you change your mind and consent for future communication between RSNWO and the listed party, a new Release of Information will need to be signed at that time.

______________________________________ ____________ ______________________________________ __________
Signature of Client/Parent/Guardian Date Signature of Staff Witness/Referral Source Date