

Mental and Emotional Wellness Centers of Ohio

Authorization for Release of Information

Name:

Date of Birth:

I hereby request and authorize both parties listed below to share information with each other:

Name of Person(s) or Agency Holding the Information

Address and phone number

Name of Person(s) or Agency Releasing the Information

Address and phone number

Both parties may release and receive to and from each other, written or verbal information specified below:

For the purpose of : _____

I understand that this form may be used to release information related to mental health treatment, including assessments and lab reports. Any release of substance abuse information must be pursuant to 42 CFR. There are other special restrictions which apply to the release of information regarding HIV, abuse reports, etc.

I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information. Expiration Date: _____. If expiration date is not specified, release will expire 90 days from date signed.

Signature of Competent Adult Printed Name of Competent Adult Date _____ am pm
Time

When applicable, Signature of: Printed Name of Substitute Decision Maker Date _____ am pm
Time

- Guardian,
- Guardian Advocate,
- Health Care Surrogate/Proxy,
- Personal Representative/Equivalent (if deceased)

Signature of Witness Printed Name of Witness Date _____ am pm
Time

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited unless the person provides specific written consent for the subsequent disclosure of this information. Ohio Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.