AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Charges for this request may apply.

I hereby grant my permission for release of the following information relating to my care between the parties named here. I am aware that once this information is released to another party, it may no longer be protected.

Samaritan Behavioral Health, Inc.	**AND**	____________________
601 Edwin C. Moses Blvd.		____________________
DAYTON, OH 45408		____________________
(937) 276-8333		____________________

This information is to be:

____ Mailed ____ Picked Up ____ Face To Face ____ Phone

____ Faxed ____ Obtained through the Community Patient Health Information Network (CPHIN)

The purpose of this request is for:

____ Continuity of care ____ Legal matter ____ Other (specify) ____________________

____ Insurance claim ____ Personal

______________________________ Patient's Name

______________________________ Date of Birth

______________________________ Name at time of treatment

______________________________ Social Security Number

______________________________ Patient's Address

______________________________ Telephone Number

Date of treatment(s) ____

This information MAY include treatment or rehabilitation for drug and/or alcohol abuse, psychiatric treatment, HIV Antibody Test (test for AIDS Virus) or AIDS and related conditions, IF they did occur. I specify that this release is to include:

____ Final Diagnosis	____ Medications Prescribed	____ Drug/Alcohol Abuse Treatment
____ Discharge Summary	____ Radiological Reports	____ Mental Health Assessment
____ History	____ Operative Reports	____ Mental Health Treatment
____ Physical Examination	____ Pathology Reports	____ Psychological Assessment
____ Consultation	____ Physician Orders	____ Drug/Alcohol Abuse Assessment
____ Emergency Room Treatment	____ Other Specified here: ____________________	
____ Laboratory Report		

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 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. I understand that this authorization may be revoked at any time in writing, except to the extent that the program or person who is to make the disclosure has already acted in reliance on it. This authorization will remain in effect for 180 days after I sign and date the form below or until ____________________. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand that I may revoke my authorization at any time and for any reason. I understand that I can lengthen or shorten the authorization period by date, event, or condition.

______________________________ Signature/Client

______________________________ Date

______________________________ Signature Parent/Guardian

______________________________ Date

______________________________ Witness

______________________________ Date

Extended Date From ____________ to ____________ Signature ____________________ Date ________

If the above signature is not that of the patient, explanation will be provided below and documentary evidence of appropriate papers shall be required to accompany this authorization. ______________________________

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