



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.
2172-A US Route 127 North
EATON, OH 45320
(937) 456-1915 • Fax:456-2208

AND

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. _____