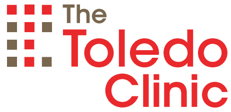

Authorization For Use or Disclosure of Mental Health or Psychotherapy Records

Location:
4235 Secor Road
Toledo, OH 43623

Patient Information

Patient Full Name: ______________________ Date of Birth: ______________

Patient Address: ______________________ Home Phone: ______________

City: __________ State ______ Zip: __________ Work Phone: ______________

Release Information From

I hereby Authorize the below physician/facility to release my medical record information:

Name/Facility: ______________________ Attention: ______________

Address: ______________________ Phone: ______________

City: __________ State ______ Zip: __________ Fax: ______________

Purpose of Request: ◯ Personal ◯ Referral or 2nd Opinion ◯ Legal ◯ Insurance ◯ Other __________

◯ Transfer from Practice/Reason?______________________

Release Information To

Name/Facility: ______________________ Attention: ______________

Address:______________________ Phone: ______________

City: __________ State ______ Zip: __________ Fax: ______________

Purpose of Request: ◯ Personal ◯ Referral or 2nd Opinion ◯ Legal ◯ Insurance ◯ Other __________

◯ Transfer from Practice/Reason?______________________

Authorization to Release Protected Information

Required - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check one

COPY FEE: *Pursuant to State Law establishing reasonable fees for copying medical records, and the Omnibus Provisions of HIPAA we reserve the right to charge a cost based fee for patient requests. Please see the accompanying letter.*

Information to be Released

◯ Please provide a 5 year summary of my records - initial_____

◯ Please provide a 7 year abstract of my records - initial_____

Authorization to Release Mental Health Records

Please release or obtain as applicable the following information for the dates of service above (the disclosure may include paper, oral and electronic exchange):

___ Bio-psychosocial Assessment ___ Progress notes ___ Current Treatment Plan

___ Psychiatric Diagnostic Evaluation ___ Medications ___ Termination Summary

___ Other (specify): ______________________

____

Other sensitive information?

Please confirm that you have put a checkmark and initialed **all** the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Sign Here ______________________ Date Here ______________

Patient's Signature **Date**

Sign Here ______________________ Date Here ______________

Parent/Legally Recognized Representative Signature** **Date****

This Authorization is valid for one year unless you specify otherwise (enter expiration date) ______________. You may revoke this Authorization at any time by providing a written statement, except to the extent that the Toledo Clinic has already completed action on it.

*The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.
** If you are the legally recognized represenatative of the patient you must provide supporting documentation.

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. The Toledo Clinic will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization.

Toledo Clinic, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race,color,national origin,age,disability or sex
Toledo Clinic, Inc., cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza,color,naciionalidad,edad,discapacidad,o sexo.