NORTHEAST OHIO BEHAVIORAL HEALTH
AUTHORIZATION FOR RELEASE OF INFORMATION

Client _____ DOB _____ SS# _____

The undersigned authorizes the release or exchange of information:

(Check one) ___From ___To ___Both

(Check One) ___From ___To ___Both

Northeast Ohio Behavioral Health
4510 Dressler Rd., NW
Canton, OH 44718
330-494-5155

Name _____
_____
_____
City _____
State _____ ZIP _____

The information is to be released for the specific purpose of: _____

___History and Physical
___Admission Report
___Diagnostic Assessment/ Psychological History
___Psychological Evaluation
___Psychiatric Evaluation
___IEP (Individualized Edu Plan)
___Medical Evaluation
___Chemical Dependency Eval
___Educational/Academic Testing
___Work/Occupational Evaluation
___Service/Treatment Plan
___Record of Current Medications
___Medication History
__Summary of Treatment Results
___Treatment/Progress Notes
___Discharge Summary
___Academic Transcripts

Other: _____

I understand that:

1. This consent will expire upon _____ (date, event or condition not to exceed 180 days). If no date, event or condition is specified then this consent will automatically expire 90 days from the date of signing.
2. This information cannot be re-released without my specific written authorization.
3. I may revoke this consent at any time by providing written revocation of consent, the agency will not release any information, except in the case where action has already been taken and where otherwise allowed by law.
4. I understand that I may review the information to be released by contacting the releasing agency/individual named above.

I expressly consent to the release of information designated above I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse (42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV) Acquired Immune Deficiency Syndrome (AIDS) test results or diagnoses (ORC3701.24.3).

X_____ _____ _____
Signature of Client/Parent/Guardian Date Signed Relationship to Client

_____ _____
Witness Date Signed

Revocation of Consent:

I hereby withdraw my consent for any further release of information as of the date indicated below:

_____ _____ _____
Signature of Client/Parent/Guardian Date Relationship to Client

PROHIBITION OF REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42CFR PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IF HELD BY ANOTHER PARTY IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATIONS STATE THAT ANY PERSON WHO VIOLATES ANY PROVISION OF THIS LAW SHALL BE FINED NOT MORE THAN $5,000, IN THE CASE OF EACH SUBSEQUENT OFFENSE. REVISED FEB. 6, 2006