Living Hope
Eating Disorder Treatment Center

AUTHORIZATION FOR RELEASE/REQUEST OF PROTECTED HEALTH INFORMATION

Per Chapter 60-9-1 SUBCHAPTER 9. CONSUMER RECORDS AND CONFIDENTIALITY 450:60-9-1. Confidentiality of mental health and drug or alcohol abuse treatment information Confidentiality policy, procedures and practices must comply with federal and state law, guidelines, and standards, and with OAC 450:15-3-20.1 and OAC 450:15-30-60.

Per Chapter 15 450:15-3-20.1 (d) 1-11. Consumer rights regarding confidentiality of mental health and drug or alcohol abuse treatment information

Patient's Name: _____ Date: _____

Date of Birth: _____/_____/_____ Medical Record Number: _____

I hereby authorize Living Hope Eating Disorder Treatment Center, PLLC to release/receive information from the following person, program or entity permitted to make the disclosure:

Contact Name: _____ Relationship to Patient: _____

Contact Facility/Practice/Other: _____

Contact Address: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Fax: _____ Email: _____

Purpose for the disclosure: _____ Continuity of Care

_____ Other: _____

My initials below signify that I consent for the following types of information to be released to the above individual/entity:

_____ 1. Drug/alcohol abuse, which is protected by Federal Regulations

_____ 2. Psychological or psychiatric conditions

_____ 3. Medical Tests including labs, x-rays, imaging, etc.

_____ 4. HIV or AIDS related records

_____ 5. Family and/or social history

_____ 6. Medical History

_____ 7. Family Group

_____ 8. Family Therapy

Restrictions (if any):_____

I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). 45 C.F.R. parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for by the

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regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: One year from date of the patient's signature on this form.

I understand exceptions to this include but are not limited to, in accordance with the Health Insurance and Portability and Accountability Act (HIPPA), the following:

- Treatment, payment and health care operations (e.g., quality improvement and credentialing) purposes. C.F.R 164.506(c)
- To report child abuse or neglect. 45 C.F.R. § 164.512(b)(1)(ii)
- To a person reasonably able to prevent or lessen a serious and imminent threat to the health or safety of a person, other or the public. (45 C.F.R. § 164.512 (j)
- To an individual exposed to or at risk of contracting a communicable disease. 45 C.F.R § 164.512(b)(1)(v)
- To report suspected abuse, neglect or domestic violence in limited circumstances. 45 C.F.R. § 164.512

"Federal Regulation (42 C.F.R. Part 2) prohibits any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Treatment services are not contingent upon or influenced by the patient's decision to permit the information release.
The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

☐ By selecting this box, I CHOOSE NOT TO AUTHORIZE Living Hope Eating Disorder Treatment Center, PLLC to release/receive my personal health information to any person, program or entity.

☐ By selecting this box, I AGREE TO AUTHORIZE Living Hope Eating Disorder Treatment Center, PLLC to release/receive my personal health information to the person, program or entity listed above.

_____ I, the patient or the authorized representative, understand that I have the right to revoke this consent at any time by providing my signature in the REVOCATION section at the bottom of this form.

The signature of the consumer or consumers legally authorized representative:

_____ _____ _____ _____
Patient Signature Date Parent/Guardian/Authorized Representative Signature Date

REVOCATION: I, as the patient or the authorized representative, hereby revoke the above authorization for Living Hope Eating Disorder Treatment Center, PLLC to release/receive my personal health information to the person, program or entity listed.

_____ _____ _____ _____
Patient Signature Date Parent/Guardian/Authorized Representative Signature Date