*O*ptima Behavioral Health, Inc.

Release of Information

Authorization/Consent for Use or Disclosure of Protected Health Information

Name of Patient: _____

Date of Birth: ____/____/____

Phone: (____) _____

Optima Behavioral Health, Inc.
81 Outerbelt Street
Columbus, OH 43213
Phone: 614-759-5075 | Fax: 614-591-4480
www.optimabh.com

I hereby authorize **OPTIMA BEHAVIORAL HEALTH** to ➡ **RELEASE ☐ OBTAIN ☐ EXCHANGE ☐** my protected health information to/from/with the following:

Individual/Entity: _____

Phone: (____) _____ **Fax:** (____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Protected Health Information (PHI) to be Disclosed:

- ☐ Initial Evaluation / History & Physical
- ☐ Treatment Plan / Summary
- ☐ Progress Notes
- ☐ All Records (Open Communication)
- ☐ Lab Report(s): _____
- ☐ Discharge / Hospital Records
- ☐ Other: _____

Dates of Service:

- ☐ All Records (Treatment Start to End)
- ☐ Last 6 Months
- ☐ Other: _____

Purpose of Disclosure:

- ☐ Continuity of Care
- ☐ Transfer of Care
- ☐ Second Opinion
- ☐ Patient Request
- ☐ Other: _____
- ☐ School
- ☐ Disability
- ☐ Insurance
- ☐ Legal

Acknowledgements:

1. EXPIRATION: I understand that this authorization/consent will expire two years from my last date of service unless revoked sooner. A photocopy of this form will be considered as valid as the original.
2. REVOCATION: I understand that I may revoke this authorization/consent at any time by notifying Dawn Schneir, Privacy Officer, at the address indicated above, in writing. This authorization/consent will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. This authorization/consent extends to all or part of the information designated above, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or HIV/AIDS. A separate authorization is required for the release of psychotherapy notes.
4. REDISCLOSURE: I understand that information used or disclosed pursuant to this authorization/consent may be subject to re-disclosure by the recipient and no longer be protected by Federal Law. For records covered by 42 CFR Part 2, this information has been disclosed from records protected by Federal Confidentiality Rules. The Federal Rules prohibit further disclosure of this information without written consent of the patient 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.
5. My healthcare and payment for my healthcare will not be affected if I do not sign this authorization/consent. I understand that my refusal to sign this authorization/consent will not jeopardize my right to obtain treatment for healthcare except where disclosure of the information is necessary for treatment.
6. I understand that I am solely responsible for any and all fees associated with this authorization/consent. In Ohio, copy fees for records are based on a per page basis and are governed by the Ohio Revised Code (ORC 3701.741).

By signing below, I acknowledge that I have read and understand this Authorization/Consent.

X _____ ____/____/____

Signature of Patient Date

_____ ____/____/____

Parent/Authorized Person Date

OR

_____

Relationship to Patient