AUTHORIZATION TO DISCLOSE INFORMATION

Please Fax to (888 450-1488) or E-mail to tault@theridgeohio.com

Name of Client: _____ Date of Birth: _____

The following programs are authorized to __disclose, __receive, or __exchange information as noted below.

Program/Facility Authorized to make Disclosure: **_The Ridge Ohio_**

Authorized Individual/Organization to Whom Disclosure May be Made: _____

Fax or E-Mail for Sending Records**:** _____

Purpose of Disclosure: __to coordinate treatment, __to gather assessment information for treatment planning, __ to gather information for ongoing treatment, __participation in the family program, __billing purposes, __other purposes (specify) _____

Type of Information to be Disclosed: __progress notes, __diagnostic assessment information, __ progress in treatment, __lab results, __urine testing, __attendance, __HIV/AIDS testing or status, __pregnancy testing, __prenatal care, __diagnosis, __information on mental illness and/or treatment, __participation in the family program, __billing information, __other information (specify)_____

Amount of Information to be Disclosed (specify): _____

I understand that my signature below will have no effect on the ability or inability to determine, limit or restrict my treatment.

This release will expire one year after the completion unless revoked by the patient at an earlier date.

Client Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Revocation: This authorization is subject to written revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it.

I hereby revoke consent in writing:

Client Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Prohibition against re-disclosure: 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 C.F.R. 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 an alcohol or drug abuse client. Drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 and 164. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.)