HIPAA Release Form Ohio

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information is Section I may result in the ability to respond to this request. This form is not a patient access request under 45 CFR 164.524. Records released pursuant to this authorization may include information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.

SECTION I

First name: _____ M.I.: _____

Last name: _____ Date of birth: _____ dd / mm / yyyy

Social security number: _____ Address: _____

City: _____ State: _____

Zip code: _____

I hereby authorize the disclosure of health information about the above individual as follows.

SECTION II

Disclosing entity: _____ Telephone number: _____

Address: _____ City: _____

State: _____ Zip code: _____

Recipient: _____ Contact information: _____

SECTION III

Reason for disclosure:

Health information to be disclosed:

Specify time period, if desired: _____

SECTION IV

This authorization will remain in effect revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration date or event: _____

I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law. I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164].

Signature of individual:
Date: _____ dd / mm / yyyy

Signature of personal representative (if applicable):
Date: _____ dd / mm / yyyy

Relationship of personal representative to individual:

- ◯ Parent
- ◯ Legal guardian
- ◯ Healthcare power of attorney
- ◯ Executor/Administrator
- ◯ N/A
- ◯ Other

For administrative use only:

Method of delivery: _____ **Date released:** _____ dd / mm / yyyy

FORM B - CONSENT FOR RELEASE OF PART 2 PROGRAM (SUBSTANCE USE DISORDER PROVIDER) INFORMATION

At Part 2 Program is a federally assisted: (i) individual or entity other than a general medical facility who holds itself out as providing, and provides, substance use disorder (SUD) diagnosis, treatment, or referral for treatment; (ii) an identified unit within a general medical facility that holds itself out as providing, and provides SUD diagnosis, treatment, or referral for treatment; or (iii) medical personnel or staff in a general medical facility whose primary function is provision of SUD diagnosis, treatment, or referral for treatment, and who are identified as such providers.

SECTION I

First name: _____ **M.I.:** _____

Last name: _____ **Date of birth:** _____ dd / mm / yyyy

Social security number: _____ **Address:** _____

City: _____ **State:** _____

Zip code: _____

I hereby authorize the disclosure of health information about the above individual as follows.

SECTION II

Disclosing entity: _____ **Telephone number:** _____

Address: _____ **City:** _____

State: _____ **Zip code:** _____

The information is to be provided to the following:

- ☐ Named individual
- ☐ Named third-party payer
- ☐ Named treatment provider entity
- ☐ Named non-treatment provider (such as an intermediary or research entity) (specify below)

If the information is to be provided to a named individual, specify below:

If the information is to be provided to a named third-party payer, specify below:

If the information is to be provided to a named treatment provider entity, specify below:

a. Named individual participant(s):

b. Named treatment provider entity participant(s):

c. Description of group or class of treatment provider entity participant(s):

Contact information: _____

SECTION III

Reason for disclosure:

Health information to be disclosed:

Specify time period, if desired: _____

SECTION IV

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration date or event: _____

Substance use disorder records of Part 2 programs disclosed pursuant to this Consent are protected by federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Any information disclosed pursuant to this Consent other than substance use disorder records or records protected under another state law may be subject to re-disclosure by the recipient. I might be denied services if I refuse to authorize disclosure of information for purposes of assessment, treatment, or payment relating to substance use disorder if refusal is permitted by state law. My refusal to authorize disclosure of information for other purposes will not affect my ability to obtain treatment or services. If I have authorized disclosure to a generally described group or class of participants in an entity which is not my treatment provider, upon my written request, I must be provided a list of entities to which my information has been disclosed pursuant to that general designation.

Signature of individual:
Date: _____ dd / mm / yyyy

Signature of personal representative (if applicable):
Date: _____ dd / mm / yyyy

Relationship of personal representative to individual:

- ◯ Parent
- ◯ Legal guardian
- ◯ Healthcare power of attorney
- ◯ Executor/Administrator
- ◯ N/A
- ◯ Other

For administrative use only:

Method of delivery: _____ **Date released:** _____ dd / mm / yyyy