Portage Path Behavioral Health

☐ Akron Clinic ◆ 340 South Broadway St ◆ Akron, Ohio 44308 ◆ 330-253-3100
☐ Barberton Clinic ◆ 105 5th St., S.E., Ste 6 ◆ Barberton, Ohio 44203 ◆ 330-745-0081
☐ North Summit Clinic ◆ 792 Graham Rd., Ste C ◆ Cuyahoga Falls, OH 44221 ◆ 330-928-2324
☐ Psychiatric Emergency Services ◆ 10 Penfield Ave. ◆ Akron, Ohio 44310 ◆ 330-762-6110

Authorization for Release of Information

☐ **File Only**

From the records of:

Name: _____ Date: _____
First Middle Initial Last Maiden (MM/DD/YY)

Date of Birth: Social Security Number:

I authorize Portage Path Behavioral Health to (check one or both): ☐ *Release To* ☐ *Obtain From*

Facility:_____ Phone #:_____

Individual:_____ Phone #:_____

Address:_____ Fax #:_____
Street City State Zip Code

I authorize the release of the following information *BY* Portage Path Behavioral Health:

☐ Dates of Treatment ☐ Diagnosis ☐ Discharge Summary ☐ Medications Prescribed

☐ Treatment Summary ☐ Current Treatment Needs ☐ Treatment Recommendations

☐ Other (Specify):_____ These Records Requested from_____ to _____

Release Format: ☐ Verbal ☐ Written ☐ Fax (For Urgent Care Needs Only)

I authorize the release of the following information *TO* Portage Path Behavioral Health

☐ Hospital Records ☐ Treatment Summary/Evaluations ☐ Discharge Summary/Evaluations ☐ Medications

☐ Psychological Testing ☐ Results of All Laboratory Tests ☐ Medical Care & Physical Exam ☐ Psychiatric Records

☐ Other (Specify):_____ These Records Requested from_____ to _____

Release Format: ☐ Verbal ☐ Written ☐ Fax (For Urgent Care Needs Only)

Specific Purpose/Need for Information:_____

THIS RELEASE WILL EXPIRE IN 180 DAYS UNLESS OTHERWISE SPECIFIED (Please Check Appropriate Box):

☐ ***90 Days*** ☐ ***180 Days*** ☐ ***One Year*** ☐ ***Length of Treatment*** ☐ ***Other Expiration Timeframe:***_____

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). I understand that the information disclosed is protected by law and may not be redisclosed without my written consent or as otherwise authorized by law; however I understand that Portage Path Behavioral Health cannot control the recipient's use of the information. I understand that treatment payment for my services, my enrollment or eligibility for benefits cannot be conditioned upon my giving authorization for disclosure of information FOR ANY OTHER PURPOSE. Records obtained from other sources and made available to PPBH may not be redisclosed to other parties. **The requestor must contact the originating facility.**

Client Signature Date	Witness Signature Date
Legal Guardian Signature (Please attach proof of guardianship) Date	Witness Relationship

TO BE SIGNED ONLY IF AUTHORIZATION IS REVOKED

This authorization can be revoked at any time by providing written notice to Portage Path Behavioral Health. I understand that any information released prior to revocation cannot be retrieved and that Portage Path Behavioral Health will not be held responsible for such. I hereby release Portage Path Behavioral Health from all legal responsibilities or liability that may arise from this act.

SIGNATURE OF INDIVIDUAL/GUARDIAN:_____DATE:_____

WITNESS SIGNATURE:_____TIME:_____DATE:_____

Blb:FORMS: 0033-04 11/91 1/92 8/93 2/94 7/97 3/99 4/03 3/04 4/05

ORIGINAL - RELEASING AGENCY COPY - REQUESTING AGENCY PINK COPY - CLIENT