Akron Clinic 340 S. Broadway Akron, Ohio 44308 330-253-3100
Barberton Clinic 105 Fifth Street, SE, Suite 6 Barberton, Ohio 44203 North Summit Clinic 792 Graham Road Cuyahoga Falls, Ohio 44221
Psychiatric Emergency Services 10 Penfield Ave. Akron Ohio 44310

PortagePath BEHAVIORAL HEALTH

Authorization for RELEASE of Protected Privileged Health Care Information

Name: _____Date of Birth _____Date: _____

I hereby authorize Portage Path Behavioral Health to release/obtain the following information identified, if present, in my records. My authorization is voluntary, and I understand my treatment, payment, or eligibility for care is not affected by my signature for release.

Release information to:	**Obtain information from:**
Facility/Individual: _____	Facility/Individual: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Fax:	Fax:

Type of Protected Information for Release (please initial *EACH* line you are requesting for release):

_____Detailed Mental Health Diagnosis and/or Treatment provided at PPBH

_____Psychiatric Testing

_____Psychological Testing

_____Discharge Summary

_____Prescriber, Therapist, Case Manager, Group Progress Notes

_____Intake Diagnostic Assessment, Diagnostic Assessment Update

_____Lab Test Results

_____Medication Order Sheets

_____Details of sexual assault counseling

_____Attendance Participation Summary

_____Treatment Plans

_____Other_____

_____Substance Use Disorder Treatment Records (Confidential Protection Rule 42CFR Part 2, Federal Rules prohibit any further disclosure of this records information unless expressly permitted by the written consent of the client to whom it pertains or otherwise permitted 42CFR Part 2).

This authorization may be revoked by the client at any time either in verbal or written format.

Witness:	**Date:**
Signature:	**Date:**

PortagePath BEHAVIORAL HEALTH

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Psychiatric Emergency Services 10 Penfield Ave. Akron Ohio
44310

Authorization for RELEASE of Protected Privileged Health Care Information

Name: _____Date of Birth _____Date: _____

Please initial each box below after you have reviewed the statement:

_____ ▪ I understand I may revoke this release either in writing or verbally at any time.

_____ ▪ I understand any information released prior to cancellation of this request may not be retrievable.

_____ ▪ I have talked to a Portage Path Behavioral Health staff member about my signature below, and any questions have been answered, including fees and payments.

_____ ▪ I agree to pay any fees and payments that apply to my Request for Protected Health Information.

_____ ▪ I understand Portage Path Behavioral Health cannot control the recipient's use of my Protected Health Information.

_____ ▪ I understand a copy of this request for release of my Protected Health Information is kept for a period of 7 years.

_____ ▪ I understand I have the right to view or inspect a copy of the Protected Health Information that is released by my signature below.

_____ ▪ I understand my treatment, payment, or eligibility of benefits cannot be conditioned upon my request for the release of my Protected Health Information.

_____ ▪ I understand Federal rules restrict the use of information to criminally investigate or prosecute any alcohol or drug abuse diagnosis of a client.

This release will expire **once treatment ends at PPBH,** unless otherwise specified:

I authorize Portage Path Behavioral Health to release my Protected Health Information designated by an initial indicated above. I understand substance use disorder records are protected under Federal Law, including governing the confidentiality of substance use in a patient record (42CFR Part 2) and applies to the Health Insurance Portability and Accountability Act (HIPAA) (1996 45CFR 160 and 164) and cannot be disclosed without written consent unless otherwise provided by the regulations. This information has been disclosed to you from records protected by federal confidentiality rules (42CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose (see 42CFR 2.31). The federal rules restrict any use of the information to investigate or prosecute regarding a crime of any patient with a substance use disorder, except as provided at 42CFR 2.12(c)(5) and 42CFR 2.65.

My signature below indicates that I am requesting the above information be released or obtained about my Personal Protected Health Information. I acknowledge I have voluntarily requested this release without coercion, and that I have been provided a copy of my request for release signed by me, dated as shown below:

Witness:	**Date:**
Signature:	**Date:**

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PortagePath BEHAVIORAL HEALTH

REVOCATION of Release of Protected Privileged Health Care Information

Name: _____ Date of Birth _____ Date: _____

I hereby REVOKE Portage Path Behavioral Health from release/obtain the following information identified, if present, in my records. My REVOCATION is voluntary, and I understand my treatment, payment, or eligibility for care is not affected by my signature for revocation.

REVOKE information release to	**REVOKE from obtaining information:**
Facility/Individual: _____	Facility/Individual: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Signature:	Date:

Type of Protected Information REVOCATION (please initial *EACH* line you are requesting for revocation):

_____Detailed Mental Health Diagnosis and/or Treatment provided at PPBH

_____Psychiatric Testing

_____Psychological Testing

_____Discharge Summary

_____Prescriber, Therapist, Case Manager, Group Progress Notes

_____Intake Diagnostic Assessment, Diagnostic Assessment Update

_____Lab Test Results

_____Medication Order Sheets

_____Details of sexual assault counseling

_____Attendance Participation Summary

_____Treatment Plans

_____Other/All_____

_____Substance Use Disorder Treatment Records (Confidential Protection Rule 42CFR Part 2, Federal Rules prohibit any further disclosure of this records information unless expressly permitted by the written consent of the client to whom it pertains or otherwise permitted 42CFR Part 2).

This Revocation may be changed by the client at any time in verbal or written format.