AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ____ Telephone Number ______________

Last 4 Digits of the Social Security Number: ________________ Date of Birth: __________________

I authorize: **CENTRAL OHIO BEHAVIORAL MEDICINE, INC.**
2000 W. HENDERSON ROAD SUITE #325
COLUMBUS OH 43220
614-538-8300 FAX 614-538-1656

TO: (CIRCLE ONE) RELEASE TO: OBTAIN FROM: EXCHANGE WITH:

Person or Agency: ____

Address: ____

Phone:________________________________ **Fax:** ____

the following information contained in the medical record regarding care and/or treatment on the following dates:

from __________ to ________ or _________ any and all treatment episodes

Please circle specific medical records/reports to be disclosed:

Evaluation Diagnosis Testing -Lab results All records

Other: ____

Purpose of disclosure (please circle): Continuity of care coordinated care Patient's request

Other: ____

Per Ohio Revised Code 3701.741, you may be charged a fee for copies of medical records.
I hereby authorize the treatment facility indicated above and its employees to release the designated information contained in my patient record. I understand and acknowledge that this authorization 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 AIDS (Acquired Immunodeficiency Syndrome), and/or may include results of an HIV test or the fact that an HIV test was performed. A separate authorization is required for the release of psychotherapy notes. I expressly consent to the release of information designated above. This authorization is valid for 365 days, unless revoked by my written notice, provided said notice is received prior to release of the above designated information. The revocation of this authorization is effective except as indicated in Central Ohio Behavioral Medicine's Notice of Privacy Practices. Information released by this authorization may no longer be protected by federal privacy rules, such as HIPAA. I understand that Central Ohio Behavioral Medicine cannot condition my treatment or payment for health care on this Authorization unless the care was provided solely to provide information to a third party.

X____ ________________________________
Signature of Patient Date Signed

X____
Relationship, if not the patient

X____ ________________________________
Witness Date Signed

ROI/6-1-11