MARYHAVEN
1791 Alum Creek Drive
Columbus, OH 43207

CONSENT FOR RELEASE OF INFORMATION

I, ______________________________, born __________________, hereby authorize
(dob)

Maryhaven
1791 Alum Creek Drive
Columbus, OH 43207-1757
614-445-8131, phone 614-445-7808, fax

To: Release ☐ Exchange ☐ Receive ☐ copies of medical and other information concerning my hospitalization and/or treatment to/with

____

Including, but not limited to, information concerning drug abuse or drug related conditions, alcoholism, psychological, and psychiatric conditions, and including the release of information containing HIV testing, AIDS diagnosis and AIDS related conditions, or permit review of the same, provided however, that such release is limited specifically to material of the following nature and extent:

The Information to be Disclosed is:

_____ Presence in treatment
_____ Evaluation/Assessment
_____ Status in treatment
_____ Progress in treatment
_____ Medical records
_____ Clinical Records
_____ Discharge date/time/type
_____ Aftercare plans/discharge summary
_____ Other ____

Purpose for Disclosure:

_____ Informing family/friends of whereabouts and condition
_____ Informing referring person(s) or agency(s) of my status
_____ Facilitating an effective aftercare program
_____ Fulfilling condition of probation, parole, or court order
_____ Providing for adequate medical care
_____ Other ____

Amount of Information to be Disclosed:

_____ Information covering the previous three months
_____ Information covering the most recent admission
_____ Other amount of information (specify) ______________________

Specific Exclusions:
This information is being disclosed to the above-captioned individual/organization for the above-stated purpose from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressively permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand this authorization may be revoked, in writing, at any time except to the extent action has been taken prior to revocation. This consent will expire one hundred eighty (180) days after date of my being discharged from this episode of care at Maryhaven, or sooner at my election, as indicated: __________
I acknowledge that I have read and fully understand this authorization as it applies to me. I also acknowledge if my referral for treatment was court ordered, I cannot revoke this release to court personnel.

______________________________ ______________________________
Date Signature of Client

______________________________ ______________________________
Staff Signature Signature of Parent/Guardian (if applicable)