



## Authorization for Use and/or Disclosure Of Protected Health Information For Ongoing Mental Health Treatment Only

**PATIENT INFORMATION (Please Print)**

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

**Please check/specify the information which you want to be used and/or disclosed as a result of this Authorization. Failure to specify (including dates) will render this Authorization invalid. Up to four different entities may be requested on this form.**

Name				
Title/Organization (if applicable)				
Street Address (if applicable include Apt #)				
City, State & Zip				
Telephone # (including Area Code)				
Date(s) of Service to be disclosed:				
<b>Information to be disclosed/exchanged includes:</b>  NOTE: A separate authorization form is required for the release of Psychotherapy Notes.	<input type="checkbox"/> Discharge Instructions <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Multidisciplinary Assessment <input type="checkbox"/> Psychological Evaluation <input type="checkbox"/> Other: _____	<input type="checkbox"/> Discharge Instructions <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Multidisciplinary Assessment <input type="checkbox"/> Psychological Evaluation <input type="checkbox"/> Other: _____	<input type="checkbox"/> Discharge Instructions <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Multidisciplinary Assessment <input type="checkbox"/> Psychological Evaluation <input type="checkbox"/> Other: _____	<input type="checkbox"/> Discharge Instructions <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Multidisciplinary Assessment <input type="checkbox"/> Psychological Evaluation <input type="checkbox"/> Other: _____
<b>Information May Be:</b>	<input type="checkbox"/> Mailed <input type="checkbox"/> Reviewed Only <input type="checkbox"/> Person to Person Meeting/Discussion <input type="checkbox"/> Picked Up By: _____	<input type="checkbox"/> Mailed <input type="checkbox"/> Reviewed Only <input type="checkbox"/> Person to Person Meeting/Discussion <input type="checkbox"/> Picked Up By: _____	<input type="checkbox"/> Mailed <input type="checkbox"/> Reviewed Only <input type="checkbox"/> Person to Person Meeting/Discussion <input type="checkbox"/> Picked Up By: _____	<input type="checkbox"/> Mailed <input type="checkbox"/> Reviewed Only <input type="checkbox"/> Person to Person Meeting/Discussion <input type="checkbox"/> Picked Up By: _____

This Authorization will expire 60 days after the date below, or sooner by my choice, in which case, Authorization will expire on \_\_\_\_\_, or \_\_\_\_\_ (event) occurs. This Authorization may be revoked at any time to the extent that use and/or disclosure has not already occurred prior to your request for revocation. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Health Information Management department, 636 – 8233. Please refer to Cincinnati Children's Hospital Medical Center's (CCHMC) Notice of Privacy Practices.

CCHMC will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations.

I, the undersigned, hereby authorize Cincinnati Children's Hospital Medical Center to use and/or disclose information from my (or give relationship) \_\_\_\_\_ medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

**Information regarding requesting records and fees is provided on the reverse of this form.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  Patient  Parent  Legal Guardian\*

The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 18 years of age, he/she is required to sign the Authorization. If CCHMC requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.

\*Documentation regarding guardianship must be provided in order to comply with the above request.

**Request Has Been Fulfilled:**  Yes, Initials \_\_\_\_\_ Date \_\_\_\_\_