Midwest Psychiatric Center, Inc.

AUTHORIZATION TO RELEASE/RECEIVE PERSONAL HEALTH INFORMATION

I hereby authorize Midwest Psychiatric Center, Inc. and the person/organization identified below to: ☐ send ☐ receive my protected health information.

Specific Identification of Person or Entity Authorized to exchange information with Midwest Psychiatric Center, Inc.			
Name:	Organization:		
Address:	City:	State:	Zip:
Phone:	Fax (if HIPAA covered entity:		

I authorize the following information to be released:

☐ Diagnosis	☐ Attendance Reports	☐ Progress Notes
☐ Closing Summary	☐ Telephone Consultation	☐ Treatment Recommendation
☐ Psychiatric Evaluation	☐ Diagnostic Assessment	☐ Other:

This authorization includes release of records relating to:

☐ Diagnosis and/or treatment for alcohol and/or drug abuse	☐ HIV test results
☐ AIDS/AIDS Related Complex (ARC diagnosis and/or treatment)	☐ Diagnosis and/or treatment related to other communicable diseases

Indicate here any additional exceptions, restrictions, or exclusions, if any, to information released.
This authorization for use/disclosure is for the following purpose:

This authorization ill remain effective for **365 days** unless an earlier day or event/condition is specified here: _____. However, I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that either party has already taken action in reliance on my authorization.
My written statement that I want to revoke my authorization should be delivered to: **Midwest Psychiatric Center, Inc. 7760 West VOA Park Dr., Suite G, West Chester, OH 45069.**

Print Name of Client:	Date of Birth:	Social Security #:
Signature of Individual/Guardian/Personal Representative	Date Signed:	Date of Expiration:

If this information has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by State and Federal law. ORC 5122.31, 45 CFR Part 2, and/or ORC 3701.243 prohibit you from making any further disclosure of it without specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is NOT sufficient for this purpose. Client/patient privacy rights are fully disclosed in practice privacy notification distributed at admission.