Lancaster	Columbus	Newark	Delaware	Chillicothe
624 East Main St.	2238 S. Hamilton Rd, Suite 200	68 W. Church St.,Suite 318	236 W. Central Ave.	114 Renick Ave
Lancaster, OH 43130	Columbus, OH 43232	Newark, OH 43055	Delaware, OH 43015	Chillicothe, OH 45601
(740) 687-0042	(614)751-0042	(740)281-1777	(740)417-9265	(740)851-4461
(740) 687-6677	(614)751-0047	(740)281-1778	(740)417-9268	(740)851-4157

RELEASE OF INFORMATION

Client Name:		Date:	
Address:		Date of Birth:	
		Social Security #	
Guardian Name:		Guardian Address:	

I hereby authorize Mid-Ohio Psychological Services, Inc. and________________________________
to communicate about the following protected information from my clinical record (those checked):

To be released by Mid-Ohio Psychological Services, Inc.

[ ] Attendance in Counseling [ ] Progress in Treatment [ ] Formal Assessment [ ] Psycho-Social History
[ ] Treatment Recommendations [ ] Alcohol/Drug information [ ] Casenotes [ ] Diagnosis/ISP
[ ] Other (specify): ____

To be released to Mid-Ohio Psychological Services, Inc.

[ ] Legal Documents	[ ] Work/School Attendance	[ ] Medical History/Treatment
[ ] Case Plan	[ ] Work/School Performance	[ ] Psychiatric/Psychological History
[ ] Investigation Info	[ ] Vocational Evaluation	[ ] Summary of Treatment
[ ] Treatment Recommendations		[ ] IEP/Multi-Factored Evaluation.
[ ] History & Physical Report	[ ] Discharge Report	[ ] AOD Treatment./History
[ ] Discovery Materials	[ ] Discipline Report	[ ] Standard Test Measures
[ ] Video Interview	[ ] Witness Statement	[ ] Compliant
[ ] Toxicology Results	[ ] Incident Report	[ ] Other (specify)

The purpose of this exchange of information is to:

[ ] Conduct a formal evaluation for: ______________________________________

[ ] Facilitate treatment

The information exchanged should reflect material collected:

[ ] In the last six months
[ ] In the last year
[ ] In the last five years
[ ] Since first contact with the client

I may revoke my consent to release this information at any time except to the extent that action will have been taken or information released prior to the revocation of my consent. I understand that treatment is generally not a condition of my signing an authorization to release information. This authorization form is valid until six months from application date or _______ (if less than six months). I hereby authorize the agency and its employees to release the designated information contained in my patient record or designated record set. 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 include results of an HIV test or the fact that an HIV test was performed. Generally, this information may not be re-released, but I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule. This information has been disclosed from records whose confidentiality is protected by Ohio Revised Code 5122.31, and Ohio Department of Mental Health Rules for Clinical Records 5119:1-7-11.This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part II. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.

	Signature:	Name(print):	Date:	Relationship
Client/Guardian				Client/Guardian
Requesting Staff				Staff Member