Authorization for Release of Information (ROI)

1. Client Name:____

   Date of Birth: __________________________ Phone: __________________________________

2. I authorize ____ to release information to:

   The Ohio Chemical Dependency Professionals Board
   77 S. High Street – Floor 16
   Columbus, OH 43215
   (614) 387-1110

3. Date(s) of service (Month, Day & Year to the best of your knowledge): ____________________________

4. **<u>Specific information to be released:</u>**

   History & Physical Exam
   Psychiatric/mental health evaluation
   Treatment Plan
   Progress Reports
   Discharge Plan
   Other (Specify): ________________________________

5. Reason for disclosure: ____

6. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon. **This authorization (unless revoked) expires one year from the date provided below.**

Signature: ____________________________________ **Date:** ______________________________
(Client/Legal Guardian/Parent)

Witness: ______________________________________ **Date:** ______________________________

This information has been disclosed to you from records protected by Federal Confidentiality rule. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly 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 information to criminally investigate or prosecute any alcohol or drug abuse client.

Your healthcare or payment for care will not be affected by whether you sign this authorization.

A photocopy or facsimile of this authorization will have the same authority as the original.

Revocation of Release of Information
I hereby withdraw my consent for this release of information:
Date: _____________________________ Signature: ____