Cleveland Integrative Counseling, Ltd.
AUTHORIZATION FOR USE/DISCLOSURE
OF HEALTH INFORMATION

Name **Date**

Address **City** **State** **Zip**

Phone Number **E-Mail**

Date of Birth **Last 4 SS#**

Authorization for Use/Disclosure of Information: I voluntarily consent to and authorize Cleveland Integrative Counseling, Ltd. to use or disclose my healthcare information during the terms of this Authorization to the recipient(s) that I have identified below.

Recipient(s): I authorize my healthcare information to be released to the following recipient(s):

Name (School)	Address	Phone
Name (Pediatrician)	Address	Phone
Name	Address	Phone
Name	Address	Phone
Name	Address	Phone

***Please draw a BOLD line through remaining open Recipients.**

Purpose: I authorize the release of my health information for the following specific purpose:

_____.

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (circle and initial next to each line):

_____ **Yes No:** Identifying information: name, birth date, sex, race, address and telephone number.

_____ **Yes No:** General Medical: medical records (except for HIV, AIDS and drug and alcohol treatment records) disability, type of services being received and name of agency providing services to me to the individual named above or me.

_____ **Yes No:** Social History: social history, treatment/service history and other personal information regarding the individual named above or me.

_____ **Yes No:** Mental Health: diagnostic assessment, treatment plans, transfer/discharge summaries, psychological assessments, psychiatric evaluations, treatment summaries, lab results and medication histories.

_____ **Yes No:** School Information: grades, attendance records, Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), Individualized Service Plan (ISP), Multi-Factored Evaluation (MFE), (Children's) Ohio Eligibility Determination Instrument (COEDI/OEDI), discipline reports, transition plans and vocational assessments regarding the individual named above or me.

Term: I understand that this Authorization will remain in effect:

- From the date of this Authorization until the _____ day of _____, 20___.
- Until the Provider fulfills this request.
- Until the following event occurs:_____

I, the undersigned, authorize CLEVELAND INTEGRATIVE COUNSELING, LTD. to release information from my medical records as described above. I understand and acknowledge that the medical record may contain Information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Cleveland Integrative Counseling, Ltd. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization. I understand there may be charges for the copying and release of Information and accept financial responsibility.

X_____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE *DATE SIGNED*

_____

Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)

_____ *(INITIAL) By signing this form as the patient's legal representative, I am certifying that there is no court order or other legal reason (such as a binding arbitration decision or final mediation agreement) prohibiting me from obtaining a copy of the requested records. This must be checked for ALL releases of records authorized by legal representatives.*

**If other than patient's signature, a copy of legal documents MUST accompany the authorization when presented; the exception is a parent of minors under 18 years of age.