WINDSOR LAURELWOOD
Center for Behavioral Medicine

35900 Euclid Avenue, Willoughby, OH 44094
Phone 440-953-3324 Fax 440-953-3276

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____ Date of birth: _____
Name of patient-please print

Authorize: Windsor Laurelwood Center for Behavioral Medicine 35900 Euclid Ave. Willoughby, OH 44094

To Release/Disclose To/Obtain From:

_____
Individual, Facility or Organization Address Phone/Fax Number

Dates of Information to be Disclosed or Obtained:
❑ Most recent ❑ Other: _____

The purpose of the disclosure is for:
❑ Insurance purposes ❑ Educational placement ❑ Legal reasons ❑ Medical treatment
❑ Discharge planning ❑ Continued treatment ❑ Personal Use ❑ Progress updates
❑ Other: _____

I understand and authorize that information contained in the documents to be released may include, but is not limited to, drug and alcohol use, abuse or dependency or related conditions, sexually transmitted disease, behavioral or mental health conditions, psychological and psychiatric conditions, human immunodeficiency virus (HIV) testing, Acquired Immunodeficiency Syndrome (AIDS) diagnosis and AIDS related conditions.

The following information may be disclosed unless otherwise declined below:

Discharge Summary, Medication Reconciliation, Initial Psychiatric Evaluation, Consultations, Diagnostic Assessment, Laboratory results, Continuing Care Plan, History/Physical, Diagnosis, Discharge Order, Crisis Safety Plan, Face Sheet, Treatment Plan, Referral Letter, Progress Notes, Advance Directive, Electroconvulsive therapy, X-Ray report, Notification of Admission Letter.
Other:_____

I decline release of_____

Consent and Signature

This authorization expires 2 years from the date it is signed, unless an earlier date, event or condition that I request is written here_____. This consent is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it.

My refusal to sign this authorization will NOT affect my ability to obtain treatment, payment or enrollment in a health plan.

** 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 the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., 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.

_____ _____ _____
Signature of Individual/Guardian/Personal Representative Date/Time Print Name

_____ _____ _____
Signature of Minor patient Date/Time Print Name

_____ _____ _____
Witness Date/Time Print Name

If the authorization 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: _____

Internal Use Only				Date sent: Sent By:		❑ Fax ❑ Mail ❑ In Person	
DC Summ		Med Rec		Initial Psy		CD Assessment	
Labs		Cont Care		Hist/Phy			
DC Order		Safety Crisis		Face Sheet			
Ref Letter		Other					