2080 Citygate Drive • Columbus, OH 43219
p: 614.445.3750 | f: 614.542.4194
www.escofcentralohio.org

educational service center
of Central Ohio

Authorization for Release/Exchange of Information

This authorizes the Educational Service Center of Central Ohio to (check all that apply):

❑ Release Information ❑ Exchange Information ❑ Release/Exchange Information ❑ Other _____

Client Name:_____ Date of Birth: _____ /_____ / _____
With: _____
_____

I herby authorize the release of the following relevant information to the above people or agencies. I understand that this release will include information checked below.

Check the following items needed:

_____	Treatment Plan/Summary	_____	Laboratory Reports
_____	Treatment History	_____	Admission History and/or Mental Status
_____	Treatment Progress	_____	Psychologist's Reports
_____	Physical History	_____	Psychiatrist's Reports
_____	Medical Exam	_____	Social Service Reports
_____	Current Medication	_____	Court Reports/Records
_____	Medication History	_____	School Records/ Consultation
_____	Physician's Orders	_____	Employment Records/Reports

Purpose or Need for Exchange:

_____ Assist in Treatment Planning
_____ Continuity of Care
_____ Other (Please specify): _____

***NOTICE – PLEASE READ*:** I understand that each authorization signed below will remain in effect **SIX** months after I sign and date the form, unless I authorize a shorter or longer authorization period. Each authorization may be withdrawn at any time in writing except to the extent that action has already been taken. Upon receipt of written revocation, further release of information shall cease immediately, except as allowed by law. Recipients of this information are forbidden to re-disclose this information without my specific authorization.

Notice to Recipient of Information: This information has been disclosed to you from records whose confidentiality is protected by Federal Laws. Federal Regulations (42 CFR Part 2) 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 is otherwise permitted by 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 this information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that if I have authorized the Educational Service Center of Central Ohio to disclose my information to persons who are not required by Federal or State law to keep the information confidential, these persons receiving my records may disclose my protected health information to others without my consent or authorization. The Educational Service Center of Central Ohio will not be responsible for the misuse or re-release of information by another individual, agency, or entity.

This consent will expire on _____ /_____ / _____.

Signature: _____ **Facilitator/Witness:** _____
Relationship: _____ **Date Signed:** _____
Date Signed: _____