CLEVELAND PSYCHIATRY ASSOCIATES LLC
CONSENT FOR THE RELEASE OF PRIVATE INFORMATION

Client Information	Name: ____________ Previous Name: ____________ Date of Birth: ____/____/____ Daytime Telephone No: (____) ______-______ Address: ____________ City: ____________ State: ________ Zip: ________
Health Information Release	☐ I authorize Cleveland Psychiatry Associates to **RECEIVE information FROM:** ☐ I authorize Cleveland Psychiatry Associates to **RELEASE information TO:** Provider/Person/Organization Name: ____________ Address: ____________ City: ____________ State: ________ Zip: ________ Telephone: ____________ Fax: ____________
Purpose of Disclosure	☐ Continuity of Care ☐ Client Request ☐ Legal/Attorney ☐ Other – please explain ____________
Health Information to be Released	☐ **Entire Health Record** (includes all records listed below) ☐ **Part of Health Record** (check one or more items) ☐ Mental Health Diagnostic Assessment ☐ Mental Health Treatment Plan ☐ Mental Health Progress Notes/Discharge Summary ☐ Substance Use Rule 25 Assessment/Diagnosis/Summary ☐ Substance Use Progress Notes/Discharge Summary ☐ Substance Use Treatment Plan ☐ Psychiatric Evaluation ☐ Medication Information/Labs ☐ Psychological Evaluation ☐ Physical Health Records ☐ Hospital Treatment/Discharge Summary ☐ Academic Records ☐ Other (please describe): ____________ Specific dates of service: ____________
External Records	☐ **All Substance Use** ☐ **All Mental Health** ☐ **Specify**: ____________
Method of Delivery	☐ **Written** ☐ **Verbal** ☐ **Encrypted email (Client only) Email**: ____________ *(Please select all that apply)*
Authorization	**This authorization expires (ends) on the following date, event, or condition.** ____________ This authorization will expire no more than 12 months from the date I sign this form unless otherwise specifically permitted by law. I understand that: • I may revoke this authorization at any time by notifying, in writing. • Revoking this authorization does not apply to information that has already been disclosed under this authorization. • I have the right to inspect or obtain a copy of the health information disclosed. • If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws. Information that goes to other persons/entities may not be protected by state or federal privacy laws and may be re-disclosed. • Cleveland Psychiatry Associates cannot prevent the re-disclosure of protected health information releases because of this request and therefore, Cleveland Psychiatry Associates is released from all liability resulting from re-disclosure. • If this release involves the disclosure of information concerning a client who is in alcohol or drug abuse treatment, this information has been disclosed from records protected by federal confidentiality rule, 42 CFR, Part 2. The federal rule prohibits 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 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient. • I do not have to sign this form. Treatment may still be provided to me if I do not sign this form. ____________ Signature of Patient or Patient's Representative ____________ Date ____________ Print Name of Representative ____________ Relationship to Client

Created 03/01/2021.