SOPHIA CENTER

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

5335 Silica Drive, Sylvania, OH 43560 Phone: 419.882.4529 Fax: 419.885.7612

Please do not fax more than 14 pages at a time.

CLIENT INFORMATION

Name: _____Phone: _____DOB: _____ /____ /_____
Address: _____
City, State, Zip: _____
I hereby authorize Sophia Center clinician _____ to:
☐ Obtain from ☐ Release to ☐ Share/discuss with

AUTHORIZED ENTITY/INDIVIDUAL/AGENCY

Name/Agency: _____
Address: _____
City, State, Zip: _____
Phone: _____FAX: _____

INFORMATION HEREBY AUTHORIZED TO BE RELEASED

Information to be shared: ☐ Written records only ☐ Verbal only ☐ Written and verbal records
Specific dates of service to be released: _____ – _____

☐ Alcohol and other Drug Diagnosis and Treatment information
☐ Attendance
☐ Billing Statements
☐ Diagnostic Assessment
☐ Diagnosis
☐ EAP Assessment
☐ EAP Notes
☐ EAP Discharge
☐ Narrative Summary
☐ Progress Notes
☐ Treatment Plan
☐ PsychoeducationalTest Results
☐ Psychological Evaluations
☐ Other: _____

PURPOSES OF DISCLOSURE

☐ Coordination and Continuity of Treatment ☐ Family Involvement. ☐ Personal ☐ Legal
☐ Insurance ☐ Transfer from Practice ☐ Other: _____

The Federal regulations 45 CFR 164.508 prohibit any further disclosure unless expressly permitted by the written consent of the person to whom it pertains. 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 understand that if the authorized recipient of the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by the recipient and will likely no longer be protected by federal privacy regulations. I understand that Sophia Center cannot control the recipient's use of the disclosed information.
- 42 CFR part 2 prohibits unauthorized disclosure of records regarding addiction services treatment.
- I understand that authorizing the use or disclosure of the above information is voluntary, and Sophia Center will not condition treatment, payment, enrollment, or eligibility on clients' authorization for the release of information.
- I understand that I can revoke this authorization at any time, except to the extent that action has already been taken by Sophia Center in reliance on this authorization, and that revocation must be signed and dated by me. Upon revocation of this authorization, further release of information shall immediately cease.

For more information about your privacy rights, please refer to Sophia Center's Policy forms.

This authorization expires one (1) year after the date signed, unless revoked prior to the expiration date.

Signature of Client: _____ Date: ____ /____ /_____
Signature of Parent/Guardian: _____ Date: ____ /____ /_____
Witness Signature: _____ Date: ____ /____ /_____

I hereby *REVOKE* my consent for the release of the above information.

Signature of Client/Representative: _____ Date: ____ /____ /_____