Highland County Board of Developmental Disabilities

AUTHORIZATION TO RELEASE RECORDS

I, (*Name*), authorize

 (*Name and address*)

to disclose to **Highland County Board of Developmental Disabilities (HCBDD)** the following information regarding:

 (*Name of Individual*), whose date of birth is.

**LIST INFORMATION BEING REQUESTED IN DETAIL**



I understand that the information to be released includes: (*check appropriate boxes, if applicable*)

Diagnoses and/or treatment for alcohol and/or drug abuse (see below for rule on re-disclosure of information on drug/alcohol diagnosis or treatment);

HIV test results;

AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment;

Diagnoses and/or treatment relating to other communicable diseases;

Except as limited as follows: 

The purpose of this authorized disclosure is (*state purpose in detail*):



Check if applicable:

This authorization is for release of protected health information for fundraising or levy purposes. The HCBDD may receive funds as a result of using my protect health information.

I understand that I may cancel this consent at any time except to the extent that action has been taken in reliance on it, by stating so in writing with the date and my signature and delivering it to:

 (*Name of receipt of PHI*)

I understand that these records are protected by Federal and Ohio law governing confidentiality rules and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that if I have authorized HCBDD to disclose my protected health information to persons who are not required by Federal or State law to keep the information confidential, these persons who are receiving the records may disclose my protected health information to others without my consent or authorization.

IF THE INFORMATION DISCLOSED INCLUDES RECORDS OF DIAGNOSIS AND/OR TREATMENT OF DRUG OR ALCOHOL CONDITION:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). 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 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.

A copy of this authorization shall have the same force and effect as the original.

If not previously revoked, this consent will terminate on: (*Date or Condition of Expiration)*

 

Date Signature

If this 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:

 

Date Signature of Personal Representative

If the individual refuses to sign, check what is applicable:

I understand that if I refuse to sign this authorization, I may not be enrolled for services with HCBDD because the HCBDD cannot get the information necessary to determine eligibility for HCBDD services. This authorization for information to determine eligibility is not for the use or disclosure of psychotherapy notes.

I understand that if I refuse to sign this authorization, I may not receive research related treatment.

I understand that this authorization is solely for the purpose of creating protected health information for disclosure to . If I refuse to sign, I will not receive health services necessary to develop protected health information to be disclosed by the HCBDD to .

For Entity Releasing Information Use Only:

Staff person releasing information: (*Signature)*

* (Printed Name)*

Date information released: 

*Revised 1/21*