



### AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SS #: \_\_\_\_\_ Phone: \_\_\_\_\_

*I hereby authorize Daily Behavioral Health, Inc to exchange medical information and pertinent records with:*

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Fax: \_\_\_\_\_

*Type of Information to be disclosed:*

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> treatment summary   | <input type="checkbox"/> progress notes        | <input type="checkbox"/> psychiatric records  |
| <input type="checkbox"/> educational testing | <input type="checkbox"/> discharge summary     | <input type="checkbox"/> written reports      |
| <input type="checkbox"/> complete chart      | <input type="checkbox"/> psychological testing | <input type="checkbox"/> verbal communication |

*Purpose of Disclosure:*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> coordination of care | <input type="checkbox"/> patient request | <input type="checkbox"/> parent/guardian request |
|---|--|--|

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Inner Health Ministries Inc has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Daily Behavioral Health, Inc at 14538 Grapeland Avenue, Cleveland, Ohio, 44111 to be effective. Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form. Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule. This release will automatically expire twelve months from the date signed. Copies of medical records not intended for medical reasons will be subject to a charge.

Faxed/Mailed Date: