EMERALD PSYCHIATRY & TMS CENTER

4995 Bradenton Ave, Suite 130, Dublin, OH 43017

Phone: 614-580-6917 **Fax**: 614-368-1357

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:	**Date of Birth:**	**Phone:**

I authorize Emerald Psychiatry & TMS Center to exchange information with:

Name: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Dates of Service to Release (From): _____ (To): _____

The Purpose of Release: ☐ Medical Treatment ☐ Disability ☐ Insurance ☐ Legal Reasons ☐ Personal
☐ Other: _____

Information to be Released/Obtained (choose from below):

☐ All information can/should be exchanged including any therapy notes and substance use records.

☐ Progress Notes	☐ Diagnosis/Diagnoses	☐ Discharge Plan/Summary
☐ Psychiatric Evaluation	☐ Medication List	☐ Substance Use History/Treatment
☐ Therapy Notes	☐ EKG Orders/Results	☐ Insurance/Billing
☐ Treatment Plan	☐ Lab Orders/Results	☐ Other:

I understand the following:

- I may be charged reasonable cost-based fees as allowed by law, for all postage and copying costs and other agreed-upon special services.
- Information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by the federal privacy requirements, including HIPAA, 45 C.F.R., part 164.
- This authorization permits the release of information which may be related to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services and/or substance use disorder treatment, 42 CFR part 2.
- For records relating to mental health services, information from other providers that is contained in the individual client record may be released from the individual client record with the written authorization provided in accordance with the provisions of this rule. For records relating to addiction services, information from other providers that is contained in the individual client record may be released from the individual client record only if the written authorization provided in accordance with this rule explicitly authorizes both the disclosure of providers records and the re-disclosure of the other providers records, Rule 5122-27-06, part 11.
- I have the right to revoke this authorization at any time by sending a written revocation to Concord Psychiatry DBA Emerald Psychiatry, but that this authorization cannot be revoked to the extent that protected health information has been previously provided in reliance on this document.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- A copy of this authorization may be used as an original. This authorization may remain valid for a maximum period of one year following the signature date.
- I have a right to receive a copy of this authorization.

_____ Date: _____

Signature of Patient or Legal Representative

_____

Relationship to the Patient

NOTE TO RECEIVER: 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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see 42 CFR 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 42 CFR 2.65