Fairhaven Counseling
746 Graham Rd.
Cuyahoga Falls, Ohio 44221
Ph. 330-940-2522
Fax 330-940-3366

Authorization to obtain/release information

Name: _____ D.O.B: _____

SSN: _____

Address: _____City: _____ Sate: _____ Zip: _____

I understand that this authorization is voluntary. I understand that my mental health information may be protected by the Federal rules for privacy of individually identifiable health information (title 45 of the code of federal regulations, parts 160 & 164), the Federal rules for confidentiality of alcohol and drug abuse patient records (title 42 of the code of federal regulations, chapter I, part 2), and/or state laws. I understand that my mental health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the federal privacy regulations.

I understand that my records may contain information regarding my mental health and substance use or dependency.

I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I understand that I may revoke this authorization at any time by notifying Fairhaven Counseling, Inc. in writing, but I do, it will not have any effect on any actions taken before it received the revocation.

_____ Please initial that you have read and agreed.

(Over)

Page 2 Fairhaven Counseling, Inc. Authorization for release of information

I hereby authorize Fairhaven Counseling, Inc. to (check all that apply**)**

____exchange / release / obtain information
_____Verbally
_____In written form only
_____ Both verbally and in writing

Person/organization receiving/communicating the information:
Name: _____

Address: _____

Phone number: _____ Extension: _____

Description of individually identifiable health information (check appropriate type(s) of information) to be released/exchanged/obtained:

____All treatment plan(s)
____Outpatient progress reports
____Substance abuse information
____All records relating to disability claim
____Other (describe): _____

The dates of records to be disclosed:
From: _____ to: _____
Month Day Year Month Day Year

The client or the client's representative must read and sign the following statements.

I understand that this authorization will expire on: _____
Month Day Year

_____
Signature of Client or legal guardian or legal representative for client of minor client

Date: _____