Authorization for Release of Information

I hereby grant permission for release of the following information relating to my care between the parties named here. I am aware once this information is released to another party, it may no longer be protected.

Greene County Adult Probation Department	**AND**	________________
45 North Detroit Street		________________
Xenia, Ohio 45385		________________
Office: (937) 562-5266		________________
Fax: (937) 562-5288 / 562-5971 / 562-5972		________________

This information is to be:

- ☐ Mailed ☐ Picked Up ☐ Face to Face ☐ Phone ☐ Fax
- ☐ Other (specify): ________________

The purpose of this request is for:

- ☐ Continuity of Care ☐ Legal Matter ☐ Personal ☐ Other (specify): ________________

________________ Client Name

________________ Date of Birth

________________ Other Names Used in Treatment

________________ SSN

Date(s) of treatment ________________

This information MAY include treatment or rehabilitation for drug and/or alcohol abuse, psychiatric treatment, HIV Antibody Test (test for AIDS virus) or AIDS and related conditions, IF they did occur. I specify this release is to include:

☐ Final Diagnosis	☐ Medications Prescribed	☐ AoD Treatment
☐ Discharge Summary	☐ Radiological Reports	☐ Mental Health Assessment
☐ History	☐ Operative Reports	☐ Mental Health Treatment
☐ Physical Examination	☐ Pathology Reports	☐ Psychological Assessment
☐ Consultation	☐ Physician Orders	☐ AoD Assessment
☐ Emergency Room Treatment	☐ Laboratory Reports	

☐ Other (specify): ________________

This information has been disclosed to you from records protected by federal confidentiality rules. 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 information to criminally investigate or prosecute any alcohol or drug abuse client. I understand this authorization may be revoked at any time in writing, except to the extent that the program or person who is to make the disclosure has already acted in reliance on it. This authorization will remain in effect for 180 days after I sign and date the form below or until ____________. I understand I may revoke my authorization at any time and for any reason. I understand I can lengthen or shorten the authorization period by date, event or condition.

________________ Signature / Client

________________ Date

________________ Signature Parent / Guardian (if applicable)

________________ Date

________________ Witness

________________ Date

Extended date from: ________ to: ________ Signature: ________________ Date: ________

I, ________________ , hereby revoke my consent for the release of information. I understand further release of this information shall cease immediately.

________________ Signature Date

________________ Witness Date