



### SIGNATURE HEALTH AUTHORIZATION TO RELEASE INFORMATION

Client Name:		Sites Visited: <input type="checkbox"/> Connections <input type="checkbox"/> ORCA House	
Client Date of Birth:		<input type="checkbox"/> Signature Health <input type="checkbox"/> Family Planning	
Client Phone:		Client ID #:	

I authorize Signature Health, Inc. to  release to  obtain from  make verbal disclosures to

Name:
Address:
Phone:
Fax:

For the purposes of:  Continuity of care  Coordinate Treatment/Services  Legal  
 Other (specify) \_\_\_\_\_

Amount of Information to be Disclosed/Obtained:  
 Information from most recent admission  Information from Dates \_\_\_\_\_ to \_\_\_\_\_

I authorize the release of the following checked items:

<input type="checkbox"/>	HIV/AIDS Related Diagnosis/Treatment	<input type="checkbox"/>	Substance Use Progress Notes	<input type="checkbox"/>	Mental Health Progress Notes
<input type="checkbox"/>	Mental Health Assessment/Summaries	<input type="checkbox"/>	Psychiatric Evaluations	<input type="checkbox"/>	Case Management Information
<input type="checkbox"/>	Chemical Dependency Assessment/Summaries	<input type="checkbox"/>	School Records/Observations	<input type="checkbox"/>	Discharge Summary
<input type="checkbox"/>	Diagnoses	<input type="checkbox"/>	Medication Records	<input type="checkbox"/>	Test Results (lab, radiology, pathology, Urine Drug Screens)
<input type="checkbox"/>	Sexual Behavior Services Information	<input type="checkbox"/>	Attendance/Appointment Lists	<input type="checkbox"/>	Medical Information
<input type="checkbox"/>	Treatment Plans	<input type="checkbox"/>	Other (specify):		

I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol and drug abuse, all of which are protected under federal or state confidentiality regulations (42 CFR Part 2; 45 CFR Part 160 et. seq.; O.R.C. § 5122.31; O.R.C. § 3701.243) and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that the health information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected under law. My failure to sign this authorization may result in my information not being released. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization. I understand that I may revoke this consent in writing at any time by providing written notice to the address and person listed below. Any revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked in writing, this authorization will expire one year from the date this authorization is signed or the date indicated: \_\_\_\_\_.

_____ Signature of Client	_____ Signature of Client's Legal Representative
_____ Date	_____ Legal Representative's Relationship to Client

Revocation of consent to release information may be made in writing to:  
38882 Mentor Ave, Willoughby, OH 44094, Attn: HIPAA Privacy Officer.

Staff Member Submitting Form: \_\_\_\_\_ Staff Witness: \_\_\_\_\_  
(if consent by phone)