GLENBEIGH
AUTHORIZATION FOR RELEASE OF INFORMATION

P. O. Box 298
Rock Creek, Ohio 44084

Phone: (440) 563-3400
Medical Records Fax: (440) 563-9661

1. Patient Name____ Patient Number: _____________________________
   Date of Birth__________________ Phone #______________________________
2. I authorize Glenbeigh to release information to:
   Name of Recipient: ____ Phone#_________________________________
   Relationship to patient (if any):____________________________________
   Company Name :(if applicable) ________________________________ Cell#_________________________________
   Address ____ Fax#___________________________________
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AND I authorize ____ to release information to Glenbeigh

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3. SPECIFIC SUBSTANCE USE DISORDER INFORMATION THAT MAY BE RELEASED VERBALLY:

☐ yes	☐ no	HISTORY & PHYSICAL EXAM	☐ yes	☐ no	LAB TEST RESULTS/XRAYS
☐ yes	☐ no	PSYCHOSOCIAL ASSESSMENT	☐ yes	☐ no	DISCHARGE SUMMARY
☐ yes	☐ no	PROGRESS REPORTS	☐ yes	☐ no	PSYCHIATRIC EVALUATION
☐ yes	☐ no	TREATMENT PLANS	☐ yes	☐ no	DISCHARGE PLAN
☐ yes	☐ no	DRUG SCREENS/BREATHALYZER	☐ yes	☐ no	BACK TO WORK LETTER
☐ yes	☐ no	ADMISSION NOTIFICATION/LETTER	☐ yes	☐ no	MEDICATION RECONCILIATION LIST
☐ yes	☐ no	PROGRESS IN AFTERCARE	☐ yes	☐ no	COORDIANTE SHORT TERM DISABILITY
☐ yes	☐ no	ATTENDING PHYSICIAN STATEMENT	☐ yes	☐ no	OTHER (specify)________________________

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4. SPECIFIC SUBSTANCE USE DISORDER DOCUMENTS TO BE RELEASED (Copy fee may apply):

a Health Information staff member will contact you if a fee is required before records are sent

☐ yes	☐ no	HISTORY & PHYSICAL EXAM	☐ yes	☐ no	LAB TEST RESULTS/XRAYS
☐ yes	☐ no	PSYCHOSOCIAL ASSESSMENT	☐ yes	☐ no	DISCHARGE SUMMARY
☐ yes	☐ no	PROGRESS REPORTS	☐ yes	☐ no	PSYCHIATRIC EVALUATION
☐ yes	☐ no	TREATMENT PLANS	☐ yes	☐ no	DISCHARGE PLAN
☐ yes	☐ no	DRUG SCREENS/BREATHALYZER	☐ yes	☐ no	BACK TO WORK LETTER
☐ yes	☐ no	ADMISSION NOTIFICATION/LETTER	☐ yes	☐ no	MEDICATION RECONCILIATION LIST
☐ yes	☐ no	PROGRESS IN AFTERCARE	☐ yes	☐ no	COORDIANTE SHORT TERM DISABILITY
☐ yes	☐ no	ATTENDING PHYSICIAN STATEMENT	☐ yes	☐ no	OTHER (specify)________________________

AMOUNT OF INFORMATION TO BE RELEASED:

5. This treatment episode only (Approximate date of your treatment; if known) ______________________________
6. Reason for disclosure: ☐Personal ☐Insurance ☐Legal ☐Disability/FMLA ☐Back to Work ☐Verify Attendance
   ☐ Treatment/Continuing Care or Other (Specify) ____
7. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon. **This authorization (unless revoked) expires one year from the date provided below.**

8. DATE: ________________________________ SIGNATURE: ____
   (Patient/Legal Guardian)**
   Witness: ____ Date: ___________________________________

This information has been disclosed to you from records protected by Federal Confidentiality rule. 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 (42CFR 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.

A photocopy or facsimile of this authorization will have the same authority as the original.

REVOCATION OF RELEASE OF INFORMATION

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I hereby withdraw my consent for this release of information. ________________________________ ___________ ________
(Signature) (Date) (Time)

I authorize **GLENBEIGH HOSPITAL** to inform the party listed above that I have **revoked** my consent to release any further information.

**If other than patient's signature, a copy of legal papers verifying authority (e.g. Power of Attorney or Death Certificate) MUST accompany the authorization when presented.

C: RELEASES, Rev. 07/87, 04/97, 02/02, 02/03, 02/04, 08/04, 11/04, 05/05, 11/05, 03/06, 03/08, 7/10, 12/17