4015 Executive Park Dr., Suite 320
Cincinnati, OH 45241
(513) 563-0488

Authorization for the Release of Patient Protected Health Information

Patient Information (Please Print)

Name: ______________________________ Date of Birth: ______________

SS#: ____________________ Legal Guardian (if applicable): ______________________

Address: ____

City: ____________________ State: ____________ Zip: ____________

☐ **Disclose Records To: ______________** ☐ **Obtain Information From: ______________**

Agency/Individual/Hospital: ______________________________________

Address: ____

City: ____________________ State: ____________ Zip: ____________

Phone: ____________________ Fax: ____________________

☐ Outpatient treatment records ☐ Discharge summary ☐ Labs/Tests ☐ Inpatient initial assessment

☐ Outpatient medical records ☐ Psychological Evaluation ☐ Telephone/Verbal Communication ☐ Med List

☐ Other: ____

The above information is requested to be released and/or received for the following purposes: ______________

I, the undersigned, authorize NeuroPsych Center of Greater Cincinnati (NCGC), to use and or disclose information, from my, or my child/legal dependent's, medical or financial records as specified. I understand and acknowledge that this authorization extends to all or any part of the records designated, which may include documentation of treatment for mental health disorder, alcohol/drug abuse/dependence, and/or HIV/AIDs test results/diagnosis. I expressly consent to the release of information as designated. Furthermore, I consent to release of the facsimile transmission of my protected health information as necessary.

This consent will expire one year after the date below (or sooner by my choice, in which case this consent will expire on __________). I hereby consent to the disclosure of these records for the purpose and extent stated above. I understand that I or legal representative may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance of this authorization. I also understand that NCGC may charge a reasonable fee for the preparation, copying and postage as allowed by state law for copies of medical records. a faxed or xeroxed copy of this release may replace the original copy. I understand that if I want to revoke this authorization that I must do so in writing and present my written revocation to NeuroPsych Center of Greater Cincinnati.

______________________________________ ______________
Patient Signature (if 18 years of age or older) Date

______________________________________ ______________
Signature of ☐ Parent ☐ Legal Guardian (check one) Date

______________________________________ ______________
Witness Signature Date

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 information unless further disclosure is expressively permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. a general authorization for release of medical information is not sufficient for this purpose. Federal rules restrict any use of information to criminally investigate or prosecute an alcohol or drug abuse patient. Please send all Health Information to: **NeuroPsych Center of Greater Cincinnati, 4015 Executive Park Dr. Suite 320, Cincinnati, OH 45241. Phone (513) 563-0488. Fax (513) 563-0428**