HWS
BEST HEALTH COUNSELING

Authorization to Obtain/Disclose Protected Health Information

1303 West Maple St. Suite 102 North Canton, OH 44720 | **Phone**: (330) 442-2664 | **Fax**: (330) 775-7889 | **Email**: medrec@hwsbesthealth.com

Client Name: _____ **Client DOB:** _____
Client SSN: _____ **Effective Date:** _____

☒ Release To ☒ Obtain From					
Name of Organization/Individual					
Address					
City		**State**		**Zip Code**	
Phone Number		**Fax Number**			
Email Address					

Purpose of Disclosure	
☒ Coordination of Care ☐ Evaluation and/or Placement ☐ Compliance with Legal Request	☐ Acquire/Maintain Benefits ☐ Treatment Planning & Implementation
☐ Other (must specify): _____	

Expiration	
☐ One-time disclosure ☐ Six (6) months ☒ Twelve (12) months (1 year)	☐ Specific Date (cannot be more than one year from effective date): _____

Purpose of Disclosure	
☒ All record types in this list may be disclosed on behalf of the above-named individual. ☐ Identifying information: name, birth date, social security number, sex, race, address, email address and telephone number. ☐ Mental Health Progress Names/Assessment/Psychosocial Assessment/Diagnostic Assessment/ Integrated Assessment including Psychiatric Evaluation/H&P/inpatient Psychiatric Record, Psychological Evaluations including Forensic/Court Psychological, Neuropsychological, School Psychological or others ☐ Discharge reports and summaries ☐ Progress Notes/Progress Reports ☐ Medication Lists ☐ Other: _____	☐ Diagnosis Lists ☐ General Medical: medical records (INCLUDING for HIV, AIDS and drug and alcohol treatment records) disability, type of services being received and name of agency providing services to me or the individual named above. ☐ School Information: grades, attendance records, Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), 'Individualized Service Plan (ISP), Multi-Factored Evaluation (MFE), (Children's) Ohio Eligibility Determination Instrument (COEDI/OEDI), transition plans and vocational assessments regarding me or the individual named above. ☐ Financial Information necessary to establish eligibility for public assistance including but not limited to pay stubs, W2's and tax returns, and other financial information.

Restrictions
☒ Check Here for No Restrictions ☐ Restrictions Apply (must specify): _____

HWS
BEST HEALTH COUNSELING

Authorization to Obtain/Disclose Protected Health Information

1303 West Maple St. Suite 102 North Canton, OH 44720 | **Phone**: (330) 442-2664 | **Fax**: (330) 775-7889 | **Email**: medrec@hwsbesthealth.com

Terms

HWS Best Health, LLC will not condition treatment, payment, enrollment, or eligibility on client's authorization solely based on refusal to consent to this release of information. The information disclosed may not be in connotation with my/the patient's treatment. In this consideration of this consent, I hereby release the source of the records from any and all liability arising therefrom. This request/authorization is valid during the pendency of any claim or demand made by or on behalf of me/the patient, and arising out of accident, injury, or occurrence to me/the patient.

☒ **NOTICE TO CLIENT:** I understand that I have the right to revoke this authorization at any time, and that the revocation will be effective except to the extent that HWS Best Health, LLC has already taken action in reliance on my authorization. I understand that records from other providers that is contained in my client record may be released in accordance to this authorization, including records relating to mental health and addiction services. I agree that a photocopy, electronic, or faxed copy of this form is acceptable in lieu of the original. I affirm that everything in the form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

☒ **ACCESS TO MY RECORD:** I understand that I have the right to have access to my own client record unless access to certain information is restricted for clear treatment reasons. If access is restricted, the treatment plan shall include the reason for the restriction, a goal to remove the restriction, and the treatment being offered to remove the restriction.

Additional Information

Please note— The records release may contain alcohol and drug abuse information and/or information about Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC).

Alcohol/Drug Abuse

☒ I authorize the release of information relating to referral and/or treatment for alcohol and drug abuse.
☐ I PROHIBIT the release of information relating to referral and/or treatment for alcohol and drug abuse.

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease

☒ I authorize the release of information relating to HIV/AIDS/sexually transmitted disease/ communicable disease.
☐ I PROHIBIT the release Of information relating to HIV/AIDS/sexually transmitted disease/ communicable disease.

Authorization

Client/Guardian's Signature		**Name of Individual Signing**		**Date**	
Staff/Witness's Signature		**Name of Staff/Witness**		**Date**	

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate services. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see 42 CFR 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 42 CFR 2.65.

OFFICE USE ONLY

Copy given to client:	☐ Yes ☐ Client Declined Copy
Identification Verified By:	☐ Government Issued Photo ID ☐ Known to Agency ☐ Known by Other Agency

Date Revoked		**Revoked By Name**		**HWS Staff Acknowledgement**	