CHILD FOCUS, INC., 551 Cincinnati-Batavia Pike, Cincinnati, Ohio 45244
(513) 752-1555
AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Client Name _____ **Date of Birth** _____

I, _____ **(please PRINT full name),** hereby authorize Child Focus, Inc. to

☐ release information to: ☐ request information from:

_____

_____

This information is to be released only to/from the individual or agency identified above.

The information is limited to the form(s) of information and the purpose(s) specified. It is not to be re-released to any other party.

Specific Information to be released to above named individual or agency:

Assessment Reports: ☐ Intake ☐ Psychological ☐ Psychiatric ☐ Psychological summary
☐ Individual Service Plan ☐ Progress Notes ☐ Diagnosis
☐ Treatment Summary ☐ Medication Summary ☐ Treatment Recommendations
☐ Acknowledgement that client is in services at CFI ☐ Attendance record at CFI
☐ HIV/AIDS Information ☐ Drug and Alcohol Treatment Information
☐ Other: (Specify)_____

Specific Information to be released to Child Focus, Inc.:

Assessment Reports: ☐ Intake ☐ Psychological ☐ Psychiatric ☐ Psychological summary
☐ Individual Service Plan ☐ Progress Notes ☐ Diagnosis
☐ Treatment Summary ☐ Medication Summary ☐ Treatment Recommendations
☐ Educational Records ☐ Drug and Alcohol Treatment Information
☐ HIV/AIDS Information ☐ Other: (Specify)_____

Treatment Purpose(s):

☐ Assessment ☐ Treatment Planning ☐ Case Management ☐ Collaboration/Coordination of Services ☐ Other: _____

I authorize information to be released from the record of ☐ the current/most recent treatment episode only; ☐ all treatment episodes.

Expiration: May not exceed 6 months unless parent/guardian/adult client agrees to a longer authorization period.
Parent/guardian/adult client must initial one of the following choices:

_____ This authorization expires six months or less from today: _____ *(expiration date, event or condition)*

_____ I agree to an authorization **in excess of six months:** _____ *(expiration date, event or condition)*

My refusal to sign this authorization will NOT affect my ability to obtain treatment. I understand that I have the right to revoke, lengthen or shorten this authorization, in writing, at any time and that the revocation will be effective except to the extent that CFI has already taken action on my authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. "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 C.F.R. 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."

_____ _____ _____
Client/Parent/Guardian Signature **Relationship** **Date**
(*Client and guardian* signature required if releasing drug/alcohol treatment information)

_____ _____ _____
Staff Person Facilitating Request **Agency/Staff Title** **Date**

COPY TO CLIENT

Revised 04-06