BELMONT PINES HOSPITAL
615 Churchill-Hubbard Road
Telephone: 330-759-2700 **Youngstown, Ohio 44505** **Fax: 330-759-1120**

AUTHORIZATION FOR USE OR RELEASE OF INFORMATION

FOR THE RECEIPIENT OF THE INFORMATION:

If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby authorize Belmont Pines Hospital to use or release health information and records obtained during the course of treatment of:

Patient Name:_____ Date of Birth:_____ SSN:_____

The information is to be disclosed to the following **persons or organizations:** Fax: _____

Person/Entity/Name:_____ Phone:_____

Address:_____

The purpose of the use or disclosure is: _____ At the request of the patient _____ Other:_____

Information to be used or disclosed includes only those items checked below with respect to services provided on or around **(insert dates of service)**: _____To_____. If this line is left blank, the treatment dates covered by this authorization are from preadmission to discharge and claims resolution.

I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses. The information to be used or released includes:

	Discharge Summary Available 14 days from discharge date		HIV/AIDS Related Information Specify:
	Psychiatric Evaluation		Psychological Testing
	Treatment Plans		Physician Progress Notes
	Laboratory Data		X-Ray Report
	Consultation Reports		Multidisciplinary Aftercare Plan
			Verbal Communication with the Treatment Team
	Billing/Financial Records		Other:
	Education Information (IEP, Grades)		Other:
	History & Physical Exam		Other:

This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release Belmont Pines Hospital from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization.
Belmont Pines Hospital will not condition treatment, payment, or eligibility for benefits on whether this authorization is signed.

1. **Expiration:** I understand that unless I revoke the authorization earlier, this authorization will automatically expire 180 days, or according to the relevant state law, from the date this authorization is signed.
2. **Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party.
3. **Refusal to sign:** I understand that I may refuse to sign this authorization and that Belmont Pines Hospital will not condition treatment on whether I sign this authorization.
4. **Certification:** I certify that I am (check whichever applies):
   - ☐ The patient, and the identification that I have provided is true and correct.
   - ☐ The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. " My relationship to the patient is that of: _____".
5. **Revocation:** I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.
6. **Copy:** I understand that I will receive a copy of this completed form.

Date	**Patient Signature (if 12 years or older)**	**Parent/Guardian**	**Date**
Date	**Staff Member/Witness Signature**	**Print Last Name**	

INTERNAL USE ONLY

I have received _____as documentation that verifies the relationship with the patient and the authority to receive health information on behalf of the patient.

Date	Employee Signature	Print Last Name