ALTERNATIVE PATHS
246 Northland Drive • Suite 200A
Medina, Ohio 44256

209-AUTHORIZATION FOR RELEASE OF INFORMATION AND RECORDS

FROM THE RECORDS OF:

NAME:_____ DATE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NO.: _____

I AUTHORIZE ALTERNATIVE PATHS, INC., TO: ❒ RELEASE TO ❒ OBTAIN FROM

Facility/Individual:_____

Address: _____City & State: _____Zip _____

Phone: _____ Fax:_____

I AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION :

❒ Diagnosis/Tx dates ❒ Progress Notes ❒ Assessments
❒ Discharge Summary ❒ Tx Plans ❒ Other _____

I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, drug/alcohol abuse, HIV test results, a diagnosis of AIDS or an AIDS related condition and I expressly consent to the release of any such information contained in the records.

Release format: ❒ Verbal ❒ Written Amount of Information: _____
(specify dates/quantity)

PURPOSE OR NEED FOR INFORMATION: _____
DATE AUTHORIZATION EXPIRES: _____
(Date or specific action)

_____ _____
Client Signature Date Witness Signature Date

_____
Legal Guardian Date Relationship

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part2.) The Federal rules prohibit you from making any further disclosures 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 CFR 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.

REVOCATION: This Authorization can be revoked at any time prior to this date or action by providing written notice to Alternative Paths, Inc. I understand that any information released prior to revocation can not be retrieved and Alternative Paths, Inc. will not be held responsible for such. I hereby release Alternative Paths, Inc from all legal responsibilities or liability that may arise from this act.

_____/_____/_____
Date of Revocation / Signature of Client or Guardian Signature of AP Staff witnessing Revocation

Original to agency releasing information, Copy to agency receiving information.