Authorization of Disclosure

I, _____, authorize Recovery & Prevention Resources (treatment provider) to disclose the following identifying information from my records (Client's medical record #_____):

- Name
- Address
- Phone Number
- Date of Birth
- Social Security Number
- Medicaid Recipient Number (if applicable).

This information will be disclosed to:

- the Delaware-Morrow Mental Health and Recovery Services Board (ADAMH Board);
- Public-Private Solutions (data processing hub for the ADAMH Board);
- the Ohio Department of Mental Health and Addiction Services.

I understand that supplemental disclosures of identifying information may be necessary and authorize such disclosures to the following parties according to the conditions specified with each:

- In the event I am a Medicaid recipient, or become a Medicaid recipient during the course of my treatment, I authorize disclosure of the previously referenced identifying information to the Ohio Department of Human Services.

- In the event I am not a resident of either Delaware or Morrow Counties, or change my residence to a location outside of either county during the course of my treatment, I authorize disclosure of the previously referenced identifying information to the MACSIS enrollment center and the ADAMH Board in my county of residence.

The purpose or need for such disclosure is:

- to determine my eligibility for publicly subsidized treatment services (to receive treatment services at a reduced fee);
- to enroll me in the appropriate ADAMH Board-approved behavioral healthcare plan; and
- to pay my treatment provider through the MACSIS computer system.

I also understand that no identifying information will be provided to the previously reference organizations for reporting and billing purposes. Examples of such information include my gender, marital status, race and ethnicity, family size, income level, diagnosis, and treatment service dates. Information necessary only for billing purposes will be eliminated after seven years. Information necessary only for reporting purposes will not be identifiable with my name.

This consent to disclose information may be revoked by me at any time except to the extent that action has been taken in reliance thereon. Unless specifically revoked earlier, this consent expires 365 days after the date of my last treatment service provided by Recovery & Prevention Resources.

Signature of Client _____ Date _____

Signature of Witness _____ Date _____

Title _____

Signature of Parent or Legal Guardian _____
(Required if client is a minor)

Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law, Federal Regulations (42 CFR Part 2) which prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is **not** sufficient for this purpose. The Federal Rules restrict any of the information to criminally investigate or prosecute any alcohol or drug abuse patient.