Recovery & Prevention Resources of Delaware and Morrow Counties, Inc.
Authorization to Disclose Client Information

I, _____ (SS# _____-_____-_____) authorize/request:

Recovery & Prevention Resources of Delaware and Morrow Counties, Inc.

118 Stover Drive
Delaware, Ohio 43015-8601
Phone: (740) 369-6811
Fax: (740) 363-8742

950 Meadow Drive Suite C
Mt. Gilead, Ohio 43338-1055
Phone: (419) 947-4055
Fax: (419) 947-4285

To exchange information with:

Name of Organization _____

Address _____

City, State Zip _____

Phone _____ Fax _____

Type of information to be disclosed: Diagnostic assessment, attendance information, treatment recommendations and/or progress, prognosis, drug testing results, discharge summary.

Amount of information to be disclosed:

___Information pertaining to the current treatment admission at Recovery & Prevention Resources

___ Information pertaining to all treatment admissions at Recovery & Prevention Resources

___ (other – specify)_____

The purpose or need for such disclosure is: to coordinate effective delivery of treatment services.

This authorization to disclose confidential information may be revoked by me at any time, except to the extent that action has been taken in reliance thereon. Unless expressly revoked earlier, this authorization will expire 90 days after my discharge from treatment at Recovery & Prevention Resources.

Signature of Client _____ Date _____

Signature of Witness _____ Date _____

Signature of Parent/Guardian if Client is a minor _____

Prohibition against re-disclosure: *This information has been disclosed to you from records protected by Federal Confidentiality Rules, 42 CFR part 2, and the Health Insurance and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164. The federal rules prohibit you from making any further disclosure of this information unless further re-disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the federal rules. 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.*

Complete the section below only if revoking this authorization to disclose confidential information.
I hereby revoke this authorization to disclose information, and understand that Recovery & Prevention Resources will honor this revocation except to the extent that they have already acted in reliance on it.

Signature of Client _____ Date _____

Signature of Witness _____ Date _____