

**CONFIDENTIAL**

***AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO:***

**OHIO PHYSICIANS HEALTH PROGRAM, INC.  
5900 Roche Drive, Suite 440  
Columbus, Ohio 43229**

**This will authorize release to/from:**

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State Zip)

\_\_\_\_\_  
(Phone)

**The Following Information:**

1. Diagnosis
2. Copy of Monitoring Agreement
3. Compliance and involvement with the treatment plan and/or monitoring agreement
4. Any change or regression in status, progress or compliance
5. Unilateral cessation of participation or advocacy relationship either on my part or that of the Ohio Physicians Health Program
6. Results of toxicology tests
7. Quarterly reports and a final summary
8. Other reports or material in my file, specifically \_\_\_\_\_

**Relative to:**

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State Zip)

\_\_\_\_\_  
(Phone)

1. I understand that the source named above will be told that the information they provide will be kept confidential and agree to waive my right to access any information obtained from these sources.
2. I understand that I have the right to withdraw this authorization at any time, but that this authorization shall expire, without my written revocation, ninety (90) days after the completion of my agreement with OPHP. I authorize a photocopy of this release to be used in lieu of an original signed document.
3. The information contained herein is confidential and is being provided in response to this written authorization.

\_\_\_\_\_  
Signature of Consenting Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date