AUTHORIZATION AND CONSENT TO RELEASE INFORMATION FORM

PRACTITIONER OR PARTICIPANT INFORMATION

Name:

Address:

City: **State:** **Zip:**

E-Mail Address:

Primary Phone Number: **Other Phone Number:**

I, _____ (Practitioner Name) hereby authorize the Ohio Professionals Health Program ("OhioPHP") to disclose the below specified information to the following authorized individual/organization for the following purpose:

☐ Monitoring services and/or One-Bite Program or Safe Haven Program monitoring services conducted by OhioPHP in relation to screening/evaluation of and/or treatment for the diagnosis of a mental health condition and/or substance use disorder.

☐ Other: _____.

Information to be released shall include any or all of the following:

Diagnosis; copy of monitoring agreement; compliance and involvement with the treatment plan and/or monitoring agreement; any change or regression in status, progress or compliance; unilateral cessation of participation or advocacy relationship either on my part of that of OhioPHP; results of toxicology tests; quarterly reports and/or final summary; mental health records (other than psychotherapy notes); and other reports or materials in my file.

RELEASE INFORMATION TO THE FOLLOWING INDIVIDUAL/ORGANIZATION

Company: **Contact Name:**

Address:

Primary Phone Number: **Fax Number:**

E-Mail Address:

1. I understand that substance use disorder records are protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent, unless otherwise provided for in the regulations.
2. I understand that I have the right to withdraw this authorization at any time to the extent the lawful recipient has not already acted in reliance upon this document. Otherwise, this authorization shall expire without my written revocation one (1) year after either (A) the completion of my agreement with OhioPHP or (B) a determination by a treatment provider that I do not have an active diagnosis for a mental health condition and/or substance use disorder. I authorize a photocopy of this release to be used in lieu of an original signed document.
3. Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance use disorder information unless the further disclosure is expressly permitted by my written authorization or as otherwise permitted by 42 C. F. R. Part 2.
4. OhioPHP will not condition treatment, payment, enrollment, or eligibility on my authorization and consent for the release of information. However, One-Bite Program and/or Safe Haven Program participants are advised that individuals are deemed to have waived any right to confidentiality that would prevent the monitoring organization conducting the One-Bite Program and/or Safe Haven Program from making reports required by Ohio law, which requires OhioPHP to screen or refer eligible individuals to evaluation and/or treatment, and to report to licensing authorities any individual who is determined to be ineligible to participate in either program.
5. I also hereby authorize OhioPHP to disclose those records as may be necessary for OhioPHP's contractors, subcontractors, or legal representatives to carry out payment and/or health care operations on behalf of OhioPHP.

_____ _____

Signature of Practitioner/Participant **Date**