OhioPHP

ADVOCACY REQUEST

OhioPHP Participant Information

Name:

Address:

City: State: Zip:

Primary Phone Number: Other Phone Number:

E-Mail Address:

Type of Request:
- ☐ Advocacy Letter – Insurance
- ☐ Advocacy Letter – State PHP
- ☐ Advocacy Letter – State Regulatory Board
- ☐ Advocacy Letter – Other
- ☐ Quarterly Reports

Is this request time sensitive? ☐ Yes ☐ No

Recipient Information

Company: Contact Name:

Address:

City: State: Zip:

Primary Phone Number: Fax Number:

E-Mail Address:

Please send via: ☐ Regular Mail ☐ Fax ☐ E-mail

Please describe the nature of action requested (i.e. type of information requested; nature of amendment, restriction, alternative communication, or complaint, etc.) in detail below.

______________________________ __________________________
Signature of Consenting Party Date

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION FORM

OhioPHP Participant Information

Name:

Address:

City: State: Zip:

E-Mail Address:

Primary Phone Number: Other Phone Number:

I, ____ (name of Participant) hereby authorize the Ohio Physicians 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 monitoring services conducted by OhioPHP in relation to evaluation of and/or treatment for the diagnosis of 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; and other reports or materials in my file.

Release of Information to the Following Individual/Organization

Company: Contact Name:

Address:

Primary Phone Number: Fax Number:

E-Mail Address:

1. I understand that my 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 ninety (90) days after either (A) the completion of my agreement with OhioPHP or (B) a determination by a treatment provider that I do not have a diagnosis of 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 this 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 ("Program") participants are advised that practitioners are deemed to have waived any right to confidentiality that would prevent the monitoring organization conducting the Program or from making reports required by Ohio law, including O.R.C. § 4731.251, which requires OhioPHP to refer eligible practitioners to evaluation and/or treatment, and to report to the State Medical Board of Ohio any practitioner who is determined to be ineligible to participate in the 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 Participant Date