Prime Behavioral Health, LLC

647 Hill Rd. North, Unit B
Pickerington, OH 43147
614-833-6900 phone
614-833-6903 fax

711 N. Columbus St., Ste. 100
Lancaster, OH 43130
740-653-6500 phone
740-653-6501 fax

AUTHORIZATION FOR RELEASE OR DISCLOSURE OF MEDICAL INFORMATION

Client Name	**Release to / Release From**
Client Date of Birth	**Address**
Client Social Security #	**Phone**
	Fax

I hereby authorize Prime Behavioral Health, LLC, to examine and /or release a copy of medical records pertaining to Medical History, Mental or Physical Condition, Services Rendered, or Treatment (including but not limited to records of Drug and/or Alcohol Abuse or Psychiatric Treatment, HIV, Testing and/or AIDS /ARC Diagnosis and/or related condition, and STD testing and/or treatment.)

USE

___Continuity of Care ___ Pursuant to legal action ___Insurance/Third party reimbursement
__Other (Specify) _____

Information Requested

___ All Records ___Other (describe) _____
Dates _____

Duration

I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent will expire 60 days after termination of treatment unless otherwise specified. If you request an exception, please write it here. _____

Restriction/Requirements

I understand that the information described above may be re-disclosed by the recipient if the information is kept as part of their records of treatment. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requiremants. In addition, any information received by Prime Behavioral Health, LLC, from another facility/physician by way of a signed authorization may be re-disclosed as part of our records of treatment unless otherwise specified.

I have been informed that certain situations may arise that requires my medical information to be faxed. This would include all types of information including drug/alcohol; psychotherapy notes or HIV related information dependent upon request.

Patient Signature/ Legal Guardian if Minor:

_____ **Date** _____

Witness:

_____ **Date**_____