# 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\_\_\_