Positive Perspectives
Counseling Centers
SPRINGFIELD • FAIRBORN
4949 Urbana Rd., Suite 201 (Rear)
Springfield, OH 45502
Phone: 937-399-3800 Fax: 937-399-3804

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD (PHI)

CLIENT NAME _____ Date of Birth _____
Mailing Address _____
Phone _____

I authorize Positive Perspectives Counseling Center (PPInc.) to use or disclose Protected Health Information (PHI) from my mental health record, which may include information about mental health diagnoses and/or treatment and substance abuse issues to:

Name: _____
Address: _____
Phone _____ FAX _____

Dates of Treatment: _____

Information to be released (Please describe with details) _____
_____
_____

Purpose of Disclosure _____

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the PPInc. at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for mental health disabilities except where disclosure of the information is necessary for the treatment.
5. My mental health care and payment for such care at PPInc. will not be affected if I do not sign this form.
6. I understand that I can request a copy of this form after I sign it.
7. I understand that in compliance with OH general statute, I may pay a fee of $0.65 per page.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ _____
Signature of Client/ Parent/Legal Guardian/Authorized Person Date
_____ Relationship to Patient