THE COUNSELING CENTER

Patient Name: _____ DOB (_____)

Date of treatment: _____ to _____

Individual or Entity requesting records: _____

Telephone: _____

Purpose of request: _____

☐ Diagnostic Assessments

☐ Treatment plans

☐ Individual counseling progress notes

☐ Group counseling progress notes

☐ Case Management and CPST individual notes

☐ Lab and urinalysis results

☐ Primary care records

☐ MAT records

☐ Medication information

☐ Discharge and Transition Summaries

☐ Other (please specify _____)

☐ Records from a specific provider (please specify _____)

This authorization will remain effective for 3 months unless an earlier date or condition/event is specified here _____.

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_____

Requesting Entity Name (printed) Date

_____

Requesting Entity Signature Date

_____

Staff Signature Date

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by State and Federal law. ORC 5122.31. 42 CFR Part 2, and/or ORC 3701 .243 prohibit you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is NOT sufficient for this purpose.