psychbc

Cincinnati: 513.504.9310
Cleveland: 216.831.6611
Louisville: 502.552.5068
Toll-free: 866.363.6611
Fax: 216.456.8128
www.psychbc.com

145 West 46th Street
Ashtabula, OH 44004

1426 Center Road
Avon, OH 44011

25101 Chagrin Blvd.
Suite 100
Beachwood, OH 44122

23625 Commerce Park
Beachwood, OH 44122

6802 West Snowville Road
Suite B
Brecksville, OH 44141

8040 Hosbrook Road
Suite 102
Cincinnati, OH 45236

7185 Liberty Centre Drive
Suite D
Liberty Township, OH 45069

10200 Forest Green Blvd.
Suite 112
Louisville, KY 40223

25111 Country Club Blvd.
Suite 290
North Olmsted, OH 44070

4212 State Route 306
(Chillicothe Road)
Suite 100
Willoughby, OH 44094

REQUEST AND AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

I, _____, born on _____, authorize _____
Patient Name (print) Clinician Name

___ **To Release/Disclose To**: ___**To Obtain Information From:**

Name _____

Relationship to Patient_____

Address _____

_____
Phone Fax

This information is for treatment planning and ongoing care.
If for other reasons, please describe:

This authorization includes release of records relating to:

___ Mental Health
___ Chemical Dependency Abuse Treatment
___ HIV/AIDS
___ Diagnoses and/or treatment relating to other communicable diseases

This authorization and request to release or obtain information from my records is fully understood as to the nature of the records and information and the implications of its release, and is made voluntarily on my part. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. In addition, if this information is redisclosed by the recipient, it will also not be protected by federal privacy regulations.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I further understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I have been informed that I may revoke this consent at any time within ninety (90) days except to the extent that action based on this consent has been taken. This consent will expire automatically after 90 days from this date of authorization unless revoked by me, or my legal representative, through written notification to the PsychBC Ombudsman at 25101 Chagrin Blvd, Suite 100, Beachwood, OH 44122, or upon the fulfillment of the above purposes, or on:_____. Any revocation will not apply to information released prior to receiving the written notification of revocation.

_____ _____ _____
Signature of Patient or Parent/Guardian Date Relationship to Patient

_____ _____ ☐ Identification Verified ____
Signature of Witness Date **(Staff Use Only)**

___ **Revoke Previous Authorization**