DIRECTIONS
COUNSELING GROUP

Authorization to Release Mental Health Information

This form, when completed and signed by you or a personal representative having legal authority to execute this authorization on your behalf, authorizes Directions Counseling Group to release protected health information (PHI) from your clinical record to the person/agency you designate.

Personal Information

Today's Date: _____ Person Requesting Release: _____

Relationship: ❑ parent ❑ guardian ❑ POA, ❑ other: _____

Client Name: _____ Client's DOB (mm/dd/yy): _____

Authorization

I authorize (the clinician) _____ of Directions Counseling Group to:
❑ release client PHI to: ❑ obtain client PHI from: ❑ exchange client PHI with:

Individual:_____ Company:_____

Address:_____ City:_____

State:_____ Zip:_____ Phone: (_____)_____

Please provide the following information (check one or more of the following):

❑ Summary of Treatment/Progress
❑ Intake Assessment
❑ Diagnosis
❑ Treatment Plan
❑ Psychological Testing Results
❑ Dates of Service
❑ Fees for Service
❑ Other: _____

The general purpose of this request is for:

❑ Evaluation/Assessment
❑ Continuity of care/Medical Care
❑ Transfer to a new clinician
❑ Disability
❑ Adoption Planning
❑ Other:_____

Method of transfer (applicable fees may apply, see other side for details)

❑ **Internal Transfer** – no fee – move to "Revocation" section

❑ **External Transfer**:

Copy PHI to (choose one): ❑ flash drive ❑ CD ❑ paper

Distributed via (choose one):

- ❑ mailed to above address
- ❑ picked up by: _____ I am aware that this person will be required to show a state issued ID in order to pick up this documentation.
- ❑ fax PHI - Fax number: _____
- ❑ email PHI - Email address: _____

I am willing to have my PHI shared via unsecured email or fax and I have been made aware of the risks that are involved by using this form of unsecured communication means. Initials: _____

DIRECTIONS
COUNSELING GROUP

Authorization to Release Mental Health Information

Fees

Phone calls, letters, summaries, reports and other non-session related items provided by a clinician are billed at $30.00/10 minute increments.

Hard copies: A client, a personal representative of a client or a third party requesting records will be charged according to what is allowable under Ohio Law as determined in Ohio Revised Code 3701.741.

Flash Drive/Disk: A client, a personal representative of a client or a third party requesting records will be charged $20 covering the cost of the device and the processing involved with transferring the PHI onto the device. *DCG will provide the device and will not accept a device from an outside source.*

Rush Orders: If a file is at our external storage facility and requires 24 turn around, a fee of $85 will be assessed and must be paid prior to the transfer being made.

Revocation

I understand that I have a right to revoke this authorization at any time by sending written notification to Directions Counseling Group. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. This consent will automatically expire one (1) year after the date of my signature as it appears below, unless indicated otherwise here: _____

Conditions

I understand that in some circumstances, by not signing this agreement, my therapist may condition providing me mental health services.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a state law applies that is more strict than HIPAA and provides additional privacy protections.

I, the undersigned, authorize this release of information:

_____

Print Client Name Date

_____

Signature of Client (or authorized Parent, Guardian or Personal Representative)

_____

Signature of Witness Date

❑ Check here if patient/client refuses to sign