Authorization of Release of Information

I, _____, whose Date of Birth is _____, authorize **Marcie L. O'Neil, MSW, LISW-S** Ph: 513-984-2333 Fax: 513-984-8333 to disclose to and/or obtain from the following information: _____

[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes

_____Other_____
_____Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is other than marketing, sale of information, research or as specified above, please specify: _____
_____

Research

- □ If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual's ability to opt into each study.

  _____.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Marcie L. O'Neil, MSW, LISW-S at 10495 Montgomery Rd. Suite 28 Cincinnati, OH 45242. 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.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated: _____

This form has been revised for use by Marcie L. O'Neil, MSW, LISW-S

Conditions

I further understand that **Marcie L. O'Neil, MSW, LISW-S** will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: treatment may be terminated if the information is deemed necessary to provide treatment or if the absence of information would/could contribute to worsening of condition.

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 will be given a copy of this authorization for my records.

X_____

Signature of Patient/Client Date

X_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____Pat Gilbert_____ _____

Signature of Staff Witness Date

This form has been revised for use by Marcie L. O'Neil, MSW, LISW-S