Main Location
452 West Market Street
Xenia, Ohio 45385
(937)376-8700
www.tcn.org

Medical Record Contact Information

452 West Market Street
Xenia, Ohio 45385
Fax:(937)376-8204

1521 North Detroit Street
P.O. Box 817
West Liberty, Ohio 43357
Fax: (937)465-0442

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ Patient Date of Birth:_____

I, authorize TCN Behavioral Health Services to request, use and/or disclose Protected Health Information with the following in the manner described.

☐Exchange Information With ☐Request Information From ☐Send Information To

If Individual, **Name of Individual**:	Relationship to Client:
If Treating Provider, **Name of Entity which has a treating provider relationship with the patient:**	
If No Treating Provider Relationship, **Name of Entity which DOES NOT have a Treating Provider Relationship with the Patient:**	
Name of Primary Contact Person(s) and/or Department: Contact with the Entity listed above is not limited to the person(s) and/or department(s) identified below:	
Address:	
City/State/Zip:	
Phone/Fax:	**Email Address:**

The information identified below by my ***INITIALS*** may be transmitted by mail, fax, in person, verbally, or by secure email:

_____ Mental Health Information contained in the descriptions selected below:

_____ Substance Use Disorder Information contained in the descriptions listed below:

INITIAL **beside the information to be Used/Disclosed/Requested**

_____ Assessment Information/ Results
_____ Individualized Service Plan/Review
_____ Treatment Recommendation
_____ Transfer/Discharge Summary
_____ Financial Information
_____ Psychiatric Evaluation
_____ Treatment Diagnosis
_____ Treatment Progress
_____ Other:_____

_____ Progress Notes/Clinical Notes
_____ Laboratory Results/Drug Screen Results
_____ Medication History
_____ Medical Information
_____ Hepatitis C Results
_____ HIV Results or AIDS/ARC Diagnosis Information
_____ Results of Psychological Testing

Amount of Information to be Disclosed:

☐ information covering all dates of service (past, present, future)
☐ information covering the most recent admission to discharge
☐ Other (specify date of treatment or admission/discharge): _____

The Purpose/Need of this Request is:

☐Continuity of Care ☐Insurance Claim ☐Legal Matter ☐Personal
☐Other:_____

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I understand that my records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance on it. In order to revoke the Authorization for Release of Information I will complete a revocation request at TCN Behavioral Health Services, Inc.

This Authorization will remain in effect for two years after I sign and date this form unless I specify an EARLIER expiration date in the space provided. Early Expiration Date:_____

Notice: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such information by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F. R. Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.
(These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.)

☐ Individual Provided Copy ☐ Individual Declined Copy

Patient Name	**Patient Date of Birth**
Signature of Patient	**Date of Patient Signature**
Print Name of Person Authorized to Sign for Patient	**Describe Authority to Sign for Patient**
Signature of Person Authorized to Sign for Patient	**Date of Authorized Person Signature**