

CONCERN SERVICES
Authorization for Use or Disclosure of Protected Health Information

I, the undersigned, hereby authorize Bethesda Healthcare, Inc., d.b.a., CONCERN Counseling Services to disclose the specified individually identifiable health information to and/or obtain information from the person/organization listed below. This authorization includes release of information concerning treatment of drug or alcohol abuse, drug-related conditions, alcohol dependence, and/or psychiatric / psychological conditions and HIV related conditions. The following information may be released:

- Assessment Treatment Plan/Progress Recommendations Diagnosis
 Review of Records Other: _____

The above information is being released to/obtained from:

Name: _____ Agency: _____
Street Address: _____ City, State: _____
Phone: _____ Fax: _____

This information is being released for use for the following purpose: _____

I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the recipient of the information and may no longer be protected by Federal law. However, if the information disclosed pursuant to this Authorization includes alcohol or drug treatment records, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit such person(s) from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the patient to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. If the information disclosed pursuant to this Authorization includes the identity of an individual on whom an HIV test is performed, HIV test results or AIDS-related treatment information, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from confidential records protected from disclosure by Ohio law. Ohio law prohibits such person(s) from making any further disclosure of this information without the specific, written, and informed release of the patient to whom it pertains, or as otherwise permitted by Ohio law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.

This statement must be signed and dated, and may be revoked at any time except to the extent action has been taken prior to revocation in reliance upon the authorization. This consent will expire ninety (90) days after the date of my signature below unless otherwise stated on the line below.

(specify date, event or condition upon which it will expire)

I acknowledge that CONCERN Services has the right to and will condition the performance of services to me on whether or not this Authorization is signed, if the purpose of such services is solely to create information for disclosure to the above named third party (such as my employer).

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the above-identified records for the purpose and extent stated above.

Print Client Name

Client/Guardian Signature

Date Signed

Social Security Number

Date of Birth

Phone Number

Print Witness Name

Witness Signature

Date Signed

