HOPEWELL
a therapeutic farm community

9637 State Route 534
Middlefield, OH 44062
P. 440-426-2000 F. 440-426-2002
www.hopewellcommunity.org

Authorization for Release of Confidential Information

FROM THE RECORDS OF:
Client Name _____ **Date of Birth** _____
(Please Print) **Last** **First** **M/I**

This release authorizes: Hopewell staff to: **[X]** receive from, **[X]** disclose to:

_____ _____ ____ _____
(Name of Organization/Person & Relationship) **City** **State** **Zip Code**

Phone # _____ **Fax #** _____

Please provide information in the format checked: [ ] Verbal [ ] Written **[X]** Verbal and/or Written

Description of Information to be released:

[ ] Diagnostic Assessment & Update	[ ] Treatment Plans	[ ] Information Shared During Staffing
[ ] Psychiatric Examinations	[ ] Orders	[ ] Progress Notes
[ ] Psychological Evaluations	[ ] Consultations	[ ] Lab Results
[ ] Nursing Assessment	[ ] Quarterly Report	[ ] Discharge Summaries
[ ] Health History & Physical	[ ] Drug Screens/Treatment	[ ] Other (specify) _____

Purpose of disclosure is to: [ ] Assess for Possible Admission [ ] Continuity of Care [ ] Updates on Progress [ ] Other _____

I understand that I, and/or my guardian, if appropriate, may shorten or lengthen the authorization period or may revoke this authorization at any time, except to the extent that action has been taken in reliance on it. If not previously shortened, lengthened or revoked, this authorization is valid for the duration of treatment and residence at Hopewell.

I understand that the information disclosed is protected by law and may not be re-disclosed without my written authorization or as otherwise authorized by law; however, I understand that Hopewell cannot control the recipient's use of the information.

I understand that my treatment, payment for my services, my enrollment or eligibility for benefits cannot be conditioned upon my giving authorization for disclosure of information.

I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse (42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV)/acquired Immune Deficiency Syndrome (AIDS) test results or diagnosis (ORC3701.24.3). I understand that the information disclosed is protected by law and may not be redisclosed without my written consent or as otherwise authorized by law; however I understand that Hopewell cannot control the recipient's use of the information. Records obtained from other sources and made available to Hopewell may not be redisclosed to other parties.

_____ _____
Signature of Individual **Date**

_____ _____ _____
Signature of Guardian/Personal Representative **Relationship to Patient/Resident** **Date**

_____ _____
Signature of Hopewell staff facilitating disclosure of information **Date**

TO BE SIGNED ONLY IF AUTHORIZATION IS REVOKED

This authorization can be revoked at any time by providing written notice to Hopewell. I understand that any information released prior to revocation cannot be retrieved and that Hopewell will not be held responsible for such. I hereby release Hopewell from all legal responsibilities or liability that may arise from this act.

SIGNATURE OF INDIVIDUAL/GUARDIAN: _____ DATE:_____

WITNESS: _____TIME: _____ DATE: _____