Pomegranate
Health Systems of Central Ohio, Inc.
Acute Hospital & Center for Psychiatry 765 Pierce Drive Columbus Ohio 43223 (614) 223-1650

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Phone Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) or category of person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

7. Name and address of Sequel Youth and Family Service facility/program to release this information:
Pomegranate Health Systems 765 Pierce Drive Columbus Ohio 43223

8. Name and address of person(s) or category of person(s) to whom this information will be sent:

9 Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Psychiatric Assessment (except psychotherapy notes), History and Physical, Psychosocial, Discharge Summary, Psychiatric Progress Notes, Testing Results (lab, x-ray, EEG, EKG, etc.), Master Treatment Plan and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

10. Reason for release of information:

☐ At request of individual

☐ Other:

11. If I do not specify a date or event in this box, this authorization shall expire 24 months from the date of my signature below.

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

(If applicable, attach supporting documentation).

I understand that after I sign this Authorization I may receive a copy. I also understand that I may inspect or copy the information to be used or disclosed, as provided for in 45 C.F.R. § 164.524.

_____ Date: _____

Signature of patient or representative authorized by law.

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AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES PURSUANT TO HIPAA

Patient Name	Date of Birth	Phone Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
2. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
3. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.
4. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 7(B).

5. Name and address of Sequel Youth and Family Services facility/program to release this information:
Pomegranate Health Systems 765 Pierce Drive Columbus Ohio 43223

6. Name and address of person(s) or category of person(s) to whom this information will be sent:

7(a). Specific information to be released:

☐ Psychotherapy Notes from (insert date) _____ to (insert date)_____

☐ Entire Record of Psychotherapy Notes

☐ Other: _____

_____

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

8. Reason for release of information:	9. If I do not specify a date or event in this box, this authorization shall expire 24 months from the date of my signature below.
☐ At request of individual ☐ Other:	
10. If not the patient, name of person signing form:	11. Authority to sign on behalf of patient: (If applicable, attach supporting documentation).

I understand that after I sign this Authorization I may receive a copy. I also understand that I may inspect or copy the information to be used or disclosed, as provided for in 45 C.F.R. § 164.524.

_____ Date: _____

Signature of patient or representative authorized by law.