Cornerstone Mental Healthcare, PLLC
Cornerstone Mental Healthcare Ohio, LLC

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Authorization for release/exchange of Information

Client Name:

Name or Organization Name: _____ Relationship to Client: _____

Address/Email: _____ Phone: _____

Fax: _____

The purpose of the disclosure is:

_____ Client requested letter
_____ Coordination of Care
_____ Obtain/maintain housing
_____ Other (describe):
_____

_____ Communicate therapy results and/or attendance
_____ Continuity of Care (ongoing)
_____ Obtain/maintain employment/supported employment

Please check any items below to release the following information (*Initial Intake Packet):

_____ Diagnosis
_____ Medications
_____ Therapy Progress Notes
_____ Treatment Plan(s)*
_____ Psychiatric Evaluation*
_____ Psychiatric Progress Notes*
_____ Other (describe): _____

_____ Service Attendance Dates
_____ Lab Reports/UA-BA Results
_____ Demographics
_____ Housing/Employment Notes (circle one)
_____ Intake*
_____ Discharge Summary

- I understand that my records and/or those of any individual(s) listed above are protected under federal and state confidentiality regulations. I understand that if I have authorized the release of substance use disorder information that the confidentiality of this information is protected by federal law (HIPAA and 42 CFR Part 2). This information cannot be disclosed or re-disclosed without my written consent, unless otherwise specifically provided for in the regulations. I understand that I may revoke this consent at any time except to the extent SHP has already acted in reliance on it. I understand and agree that this release form may be sent to the agencies and persons identified above. Regarding information not pertaining to a substance use disorder, a disclosure authorized by me carries with it the potential for re-disclosure by the recipient and that federal privacy laws may no longer protect that information.
- SHP may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this Authorization. I will receive a copy of this Authorization for my records.
- This consent expires two (2) years from date of signature.

_____ _____
Signature of Client, Parent/Guardian (for client under 15 years of age), or Authorized Representative, including authority to act for client.

Date of Signature

Authorization to Revoke Release

_____ _____
Signature to Revoke Authorization **Date of Signature**